S. HRG. 100-323

MENTAL HEALTH SERVICES UNDER MEDICARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

JUNE 18, 1987

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MENTAL HEALTH SERVICES UNDER MEDICARE

THURSDAY, JUNE 18, 1987

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 11:54 a.m. in room SD-215, Dirksen Senate Office Building, the Honorable George J. Mitchell (chairman) presiding.

Present: Senators Mitchell, Matsunaga, Chafee, and Durenberger.

[The press release announcing the hearing and the opening statement of Senator Heinz follows:]

[Press Release No. H-53]

FINANCE SUBCOMMITTEE ON HEALTH TO HOLD HEARINGS ON COVERAGE OF PRESCRIPTION DRUGS AND MENTAL HEALTH SERVICES UNDER MEDICARE

WASHINGTON, DC.—Senator George J. Mitchell (D., Maine), Chairman, announced Thursday that the Subcommittee on Health of the Senate Finance Committee will hold hearings on coverage of prescription drugs and coverage of mental health services under the Medicare program. Chairman Mitchell stated that the purpose of the hearings is to examine the feasibility of various options for including coverage of these items and services under Medicare.

The principles to be examined with respect to prescription drug coverage include the nature of the coverage (catastrophic or basic), the scope of the coverage (including any limits on the types of drugs that might be covered), the use of deductibles, coinsurance, and other cost sharing, the administration of the benefit, reimbursement, quality assurance, cost and utilization control, and the financing of the benefit.

The principles to be examined with respect to mental health services include the nature of any changes in coverage (catastrophic or basic), changes in the types of services that are subject to the current coverage limits, and the financing of any benfit expansion.

The hearings will be held on Thursday, June 18, 1987 in Room SD-215 of the Dirksen Senate Office Building. The hearing on coverage of prescription drugs will begin at 9:00 A.M., and the hearing on mental health services will begin at 11:00 A.M.

OPENING STATEMENT BY SENATOR JOHN HEINZ (R-PA)
FINANCE COMMITTEE SUBCOMMITTEE ON HEALTH HEARING
THURSDAY 18 JUNE 1987

Mr. Chairman, good morning. I want to thank you for calling this hearing today to look at the issue of broad prescription drug coverage for older Americans under Medicare. If the One Hundredth Congress leaves but one legacy, it should be the demonstrated willingness to tackle difficult problems head on. No where is that challenge more vital than in health care.

Providing prescription drug coverage for America's elderly is a dilemma not because the need for coverage is an issue, but because of the various costs inherent in a solution.

The need for coverage is well documented and highly quantifiable. In 1987, for example, older Americans will spend over $9 billion on prescription drugs, with millions of aged individuals paying over $500 annually for medication to treat chronic illnesses such as arthritis and hypertension. With drug costs escalating 2 1/2 times faster than other consumer prices, cost is cited by the elderly as the second most important reason for not filling a prescription. By what twisted process of reasoning, Mr. Chairman, can we commend ourselves for giant strides in combating and controlling disease with drugs, while denying access to these modern miracles by reason of cost?

One of my constituents from Pittsburgh is typical of millions of older indivduals facing large out-of-pocket expenses for drugs. He wrote that his income from Social Security was "devastated by the costs of prescription drugs." His costs averaged $180 per month for the past year and he knows of "many others whose limited means are similarly being ravaged." How tragic that millions face the choice of drugs or food and housing!

But I know the naysayers on a prescription drug benefit point to at least four reasons to avoid coverage. I would like to address each of these briefly.

Some say the drug benefit necessarily encourages overutilization. I became painfully aware of the emotional and physical agony of seniors suffering drug misuse at a 1983 Aging Committee hearing. I have two observations to lay before my colleagues on this issue.

First, while overutilization is a problem, we also have substantial evidence of drug underutilization because of cost. Unnecessary hospitalizations, even deaths--certainly unwarranted suffering and pain--have been tied to the failure to take prescribed drugs. It's a simple equation of need: substract essential living costs from a limited, fixed income and nothing remains for medications. Second, if Medicare covers drugs, we can better monitor use--and hopefully protect against both under- and overutilization.

Some say covering drugs will break the already dangerously thin thread of financial security in the Medicare program. There is no question that a drug benefit will be expensive. But preliminary studies suggest there will be savings to Medicare to help offset the costs.

A simple, but graphic case in point is the case of Mrs. A and Mrs. G. Both suffered with terminal cancer, and had essentially the same treatment regimen. Both were treated in the Washington metropolitan area. The difference in their care was that Mrs. G received chemotherapy in a local hospital -- because Medicare would pay only in the hospital -- while Mrs. A was treated in her home under a private insurance plan. The difference in cost is astonishing: private insurance paid $1100 for Mrs. A's one day therapy, while Medicare paid out $1900 -- $800 more for the same treatment. We must find some way of taking into account the economic efficiencies that will result when Medicare covers outpatient prescription drugs.

The third argument against prescription drug coverage is that the benefit will be an administrative nightmare -- if not an administrative impossibility. Again I would focus the Committee's attention on the proven to dispel the theoretical. Eight States now provide an outpatient prescription drug benefit for low income elderly, and all but two States do so for Medicaid beneficiaries. The largest of these programs for the poor, and one often cited as a model program, is the Pharmaceutical Assistance Contract for the Elderly in Pennsylvania (PACE). I look forward to hearing a great deal of

concrete advice from a representative of the PACE program this morning.

Finally, the naysayers argue that a prescription drug benefit for Medicare will cause prices to rise rapidly and force Congress to take draconian steps to cut costs, thereby inhibiting the ability of the drug manufacturers to perform the expensive research necessary to find new miracle cures. The fears of the drug companies were echoed in these very chambers more than 20 years ago by physicians who feared that Medicare would lead to socialized medicine and the demise of medicine as we know it. All I can say is that few physicians are arguing today that we should scrap Medicare, even with our current cost-containment efforts. I am confident that Medicare coverage of prescription drugs can contain costs for consumers while ensuring adequate funds for research.

Mr. Chairman, again I thank you for an opportunity to look at this critical issue and feel confident we will be able to reach consensus on a solution.

Senator MITCHELL. Good morning. Our purpose in holding this hearing today is to examine the existing mental health benefits under the Medicare Program, an examination that is long overdue.

Between three million and five million of our Nation's elderly have significant mental health problems. Many more of those over age 65 are in need of a brief period of counseling when facing a severe crisis, such as the death of a spouse or being forced to move from a home in which they have lived for most of their adult lives.

While those Medicare beneficiaries under age 65 who are disabled account for only three million of the approximately 30 million beneficiaries, they use a disproportionate share of mental health benefits under the program. Many of these disabled persons qualify for Medicare because of chronic mental illnesses, which require extensive treatment over a long period of time.

The mental health benefit under Medicare has not been examined carefully in 20 years. During that time there have been many advances in medical management of mental illness and in forms of treatment particularly for those with chronic illness. We have a responsibility to reexamine the existing benefit in light of these changes and then to work to design a benefit that will better meet the needs of both elderly and disabled Medicare beneficiaries.

I look forward to the testimony to be presented by the witnesses today, particularly from the three distinguished members of the House, and to work with my colleagues on this committee and those in the House to improve the mental health benefit under the Medicare program.

I am pleased that we are joined today by Senator Durenberger who served for six years as chairman of this subcommittee and who was responsible for much of the important legislation now covering those in Medicare. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, you know how strongly I feel about the issue. And I appreciate your comments and I won't add to that in deference to our witnesses who have been waiting for quite a while.

Senator MITCHELL. Thank you, Senator Durenberger.

Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

I want to say that we are grateful for the three witnesses coming here today from Congress, and the others, and I am interested in this subject also. Unfortunately, like everybody else, I seem to have conflicts and will certainly review the testimony that takes place here today. Thank you, Mr. Chairman.

Senator MITCHELL. Thank you, Senator Chafee.

I want to begin by apologizing to our colleagues from the House for the lengthy delay. As you know, we had a prior hearing on the prescription drug benefit under Medicare and it, perhaps predictably, ran longer than expected.

We will now be pleased to hear from the three House members, and we can proceed in any order you like, whatever you decide. Or you are listed on the agenda: we would be glad to go in that direction.

STATEMENT OF HON. THOMAS J. DOWNEY, U.S. REPRESENTATIVE FROM THE STATE OF NEW YORK

Congressman DOWNEY. Thank you, Mr. Chairman. I suspect I look more youthful than my colleagues. I have the advantage of being senior and we have decided that I would start off.

Senator MITCHELL. You are the oldest.

Congressman DOWNEY. I am also the oldest. That is right. [Laughter.]

Congressman DOWNEY. Mr. Chairman, let me just say that we welcome this opportunity. We know the work that you and Senator Matsunaga have done on this particular issue.

Senator MITCHELL. I'm sorry, Congressman Downey. I apologize to Senator Matsunaga. I was not aware that he was present in the changeover from the other hearing. And I wonder if you have a statement that you would care to make, Senator Matsunaga, an opening statement.

Senator MATSUNAGA. I will hear them first.

Senator MITCHELL. All right. Fine. My apology to you, Senator Matsunaga. I was not aware of your presence. Please proceed, Congressman Downey.

Congressman DOWNEY. Mr. Chairman, we in the House have paid a great deal of attention to this issue. And I promise to be very brief because we know that your schedule is long. For too long the mental health care needs of the elderly have been simply unmet. We know that between 15 to 20 percent of older Americans who are particularly vulnerable to emotional suffering have significant mental health problems; however, senior citizens receive only 7 percent of inpatient psychiatric services, 6 percent of community mental health services, and 2 percent of services delivered in private psychiatric offices.

Proper treatment of mental health problems for the elderly have been severely limited because of the dark-ages approach we have allowed Medicare to take toward mental health. Our understanding and treatment of mental health disorder have advanced significantly since 1965, when we wrote the Medicare legislation, but the discriminatory limits for both inpatient and outpatient treatment of mental health problems have never been changed.

I have introduced legislation in each Congress since 1979 that would eliminate the discriminatory Medicare limits on mental health care. However, this year we are on the verge of bringing Medicare into the twentieth century on the mental health question. And as you know, both the Ways and Means Committee and the Energy and Commerce Committees have included significant changes in the mental health benefit in the catastrophic health care legislation.

These changes essentially raise the current $250.00 outpatient cap for mental health problems. And while I think we ultimately need to do away with the limits on both inpatient and outpatient treatment of mental disorders, the changes proposed in the House will improve access to mental health care for senior citizens.

Let me be frank because time is short. I am here to urge you that your committee consider the inclusion of improvements in mental health care benefit in the context of catastrophic health

care legislation. My point is simply that if we put it, or attempt to put it in reconciliation or in some other legislation, you will have one vehicle and we will have another and that will be a problem for us.

Let me say one other thing since I am the newly appointed acting chairman of the Public Assistance Subcommittee in Ways and Means, that we have just marked up a fairly significant and, I believe, one you will probably be able to support, change in legislation on public assistance. And we are including that probably in our reconciliation package. If you were to include that—and it is my hope, and this outcome will depend on what Senator Moynihan and others want to do over here—but if we have that issue, plus this issue, plus revenue, in reconciliation, I think we will make that train, frankly, much too large to be pulled through this legislative station.

We need to deal with mental health. I don't think I need to convince either Sparky or you, George, about this. It has got to be done. And the only way it can be done, in my view, is to put it in catastrophic and we can work out our differences. Frankly, it is not as much as I would like, but it seems to be as much as Congressman Levin and Congressman Coyne could get in the process.

So, please, do not reconcile it to reconciliation because it will die, I am afraid, there. Please put it in catastrophic where it belongs.

Senator MITCHELL. Thank you very much, Congressman Downey.

Now since we are going by seniority, who is next?

Congressman COYNE. Congressman Coyne.

Senator MITCHELL. Congressman Coyne. All right. In other words, it is inverse proportion to age than already exists. [Laughter.]

Congressman LEVIN. As always, you are correct. [Laughter.]

[The prepared written statement of Congressman Downey follows:]

STATEMENT OF CONGRESSMAN THOMAS J. DOWNEY
BEFORE
SUBCOMMITTEE ON HEALTH

June 18, 1987

Mr. Chairman and members of the Committee, I want to thank you, not only for holding this hearing today, but for your graciousness in receiving this delegation from the other body. We know your time constraints and promise to be brief.

For too long the mental health care needs of the elderly have been unmet. We know that between 15 to 20 percent of older Americans, who are particularly vulnerable to emotional suffering, have significant mental health problems. However, senior citizens receive only 7 percent of inpatient psychiatric services, 6 percent of community mental health services, and 2 percent of services delivered in private psychiatrists' offices.

Proper treatment of mental health problems for the elderly has been severely limited because of the "dark-ages" approach we have allowed Medicare to take toward mental health. Our understanding and treatment of mental health disorders has advanced significantly since 1965, when Congress enacted Medicare. But the discriminatory limits for both inpatient and outpatient treatment of mental health problems have never been changed.

I have introduced legislation in each Congress since 1979 that would eliminate the discriminatory Medicare limits on mental health care. However, this year we are on the verge of bringing Medicare into the twentieth century on the mental health question. As you know, both the Ways and Means and Energy and Commerce Committees have included significant changes in the mental health benefit in catastrophic health care legislation. These changes essentially raise the current $1000 outpatient cap for mental health problems. While I think we ultimately need to do away with limits on both the inpatient and outpatient treatment of mental disorders, the changes proposed in the House will improve access to mental health care for senior citizens

Let me be frank because I know your time is short. I am here today to urge that your Committee consider the inclusion of improvements in the mental health benefit in the context of catastrophic health care legislation. My point is: Why muddy the waters by having the same benefit in different pieces of legislation? Catastrophic health legislation is on the move and the sooner we can fix the mental health benefit problem the better. Thank you.

STATEMENT OF HON. WILLIAM J. COYNE, U.S. REPRESENTATIVE FROM THE STATE OF PENNSYLVANIA

Congressman COYNE. Thank you very much, Senator.

I am here today with my two Ways and Means colleagues to express my concern over the present inadequate Medicare reimbursement for outpatient mental health services.

Since the inception of the Medicare program, coverage for mental health services has been extremely limited, particularly for outpatient care. The original outpatient limit established by Medicare covered only $500.00 of services, at an effective coinsurance rate of 50 percent, for a maximum annual reimbursement of $250.00. As this limit has never been updated, the 1965 $250.00 worth of coverage currently has a purchasing power of only $57.00. As the purchasing power of these capped dollars has diminished, so too have the possibility of acquiring adequate mental health services for Medicare beneficiaries.

The Ways and Means Committee, in its recently approved catastrophic bill, recognized the need for a long overdue improvement in Medicare's mental health benefit. The committee approved a modest step in the right direction. I emphasize the word "modest" because the Ways and Means Committee agreed to an increase in the outpatient cap from $250 to $1,000. If the committee had chosen to adjust the cap for inflation, it is estimated that the benefit would now be worth $2,000.

I ask for your support for an increase in Medicare's mental health benefit. Such an increase will now only begin to eliminate some of the social stigma associated with mental illness, but it will also encourage treatment in less expensive outpatient settings rather than the repeated episodes of costly hospitalization.

And I thank you for the opportunity to testify.

Senator MITCHELL. Thank you very much, Representative Coyne. Now Representative Levin. Welcome, Sandy.

[The prepared statement of Congressman Coyne follows:]

statement of Congressman Coyne

I come before you today with my Ways and Means colleagues, Sander Levin and Tom Downey, to express my concern over the present inadequate Medicare reimbursement for outpatient mental health services. Since the inception of the Medicare program, coverage for mental health services has been extremely limited, particularly for outpatient care. The original outpatient limit established by Medicare covered only $500 of services, at an effective coinsurance rate of 50%, for a maximum annual reimbursement of $250. As this limit has never been updated, the 1965 $250 dollars worth of coverage currently has a purchasing power of only $57 dollars! As the purchasing power of these capped dollars has diminished, so too, has the possibility of acquiring adequate mental health services for Medicare beneficiaries.

The Ways and Means Committee, in its recently approved catastrophic bill, recognized the need for a long overdue improvement in Medicare's mental health benefit. The Committee approved a modest step in the right direction. I emphasize the word modest because the Ways and Means Committee agreed to an increase in the outpatient cap from $250 to $1,000. If the Committee had chosen to adjust the cap for inflation, it is estimated that the benefit would now be worth over $2,000!

I ask for your support for an increase in Medicare's mental health benefit. Such an increase will not only begin to

eliminate some of the social stigma associated with mental illness, but it will also encourage treatment in less expensive outpatient settings rather than repeated episodes of costly hospitalization.

Thank you.

STATEMENT OF HON. SANDER M. LEVIN, U.S. REPRESENTATIVE FROM THE STATE OF MICHIGAN

Congressman LEVIN. Thank you.

It is very good to be here with all of you. Four or five quick points. The first one: this is just about reflective of inflation. And I don't see how in good conscience we can refuse to keep up with inflation in the area of mental health.

Second, I have had a chance to read Dr. Helm's testimony, and the argument seems to be that 90 percent presently fall within the $250, and it is going to cost a couple hundred million dollars to cover those who are not covered, $85 million in 1989, $335 million by 1992. So if you average that out, perhaps $200 million a year.

What does that say? Even if you accept the 90 percent figure, and I don't know where it comes from. It says that there are thousands of people who are uncovered who are in the greatest need. And their response seems to be summed up: It's already covering the needs of the vast majority of beneficiaries. Is that how we are going to handle mental health problems in America?

And then it said, well, the States have programs. I just wonder if anyone is going to argue that they are adequately covering the mental health needs of senior citizens. Congressman Downey pointed to the statistics. I think they are unchallenged. The elderly—this is from the second page of my testimony—who suffer disproportionately from emotional problems, depression, dementia, and other disorders, receive only 6 percent of community mental health services.

So I don't understand it. And then it said, well, handle it through reconciliation. When we have all those other issues to handle? Then it said, well, it isn't catastrophic. It doesn't fit right within the exact contours of a catastrophic bill. But this committee has considered a few other areas, as we did in the House—home health benefits and skilled nursing benefits—where there are clear-cut needs, as is true here. And we are really talking about a situation for those people who are uncovered, inadequately covered, for whom it is catastrophic.

And, finally, it said, the advisors would say to the President that he should veto it. And a couple of very quick points on that.

We are not looking for a confrontation on mental health issues. It is the last area we want confrontation on. I don't think we want to run scared on matters that matter deeply to us by threats of veto. I hope we will pursue this vital area within our own lights, and that the Administration will then sit down and talk with us and see the light. I don't see how in good conscience we can allow a benefit 20 years old, to $250, in this area of mental health stay the way it is.

Thank you. And we wish you well.

Senator MITCHELL. Thank you very much, gentlemen, for your very thoughtful and helpful statements.

[The prepared written statement of Congressman Levin follows:]

SANDER M. LEVIN
17TH DISTRICT, MICHIGAN

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TESTIMONY OF CONGRESSMAN SANDER M. LEVIN

ON MEDICARE COVERAGE FOR OUTPATIENT MENTAL HEALTH CARE

JUNE 18, 1987

Mr. Chairman and Members of the Subcommittee,

Thank you for the opportunity to testify today on the Medicare outpatient mental health benefit.

The importance of catastrophic protection under Medicare is not lost on any of us. Almost everyone in our government, from the President on through the Congress, has made a commitment to respond to a very important need for seniors -- the lack of insurance protection against prolonged, expensive acute illness. This is not, however, the only catastrophic health care need that Medicare fails to meet. I am pleased by the emerging consensus within our various Committees that we should take this opportunity to address the other most significant areas of unmet need. Both the Finance and Ways and Means Committees have reported changes in the skilled nursing, hospice and home care benefits which will help fill the void in services outside the hospital. In addition, both of our Committees have approved a new,

income-related supplemental premium, which will improve the fairness of the catastrophic benefit and help us make future improvements in Medicare without increasing burdens on the poor elderly. All of these changes address unmet catastrophic health care needs, and we should be proud of our progress thus far.

The issue under consideration today -- outpatient mental health care -- clearly falls into this category of important, unmet health care needs. Frankly, I cannot imagine a more appropriate legislative vehicle for improving Medicare's mental health coverage than the catastrophic bill. The current outpatient mental health benefit is, itself, a catastrophe. Today, almost without exception, every health insurance plan -- private, state and federal -- offers better outpatient mental health coverage than we provide our elderly through Medicare.

We all know the litany of neglect. A minimal benefit was established over 20 years ago when we knew little about mental illness. Even though our knowledge and our ability to treat mental illness have dramatically improved, the benefit has never been increased. Today's Medicare outpatient mental health benefit is worth less than $60. It buys no more than 7 or 8 outpatient visits, leaving the elderly on their own to pay for needed care. In terms of how little coverage Medicare provides, mental illness quickly becomes catastrophic for the elderly.

What is the result? The elderly, who suffer disproportionately from emotional problems, depression, dementia, and other disorders, receive only 6 percent of community mental health services and only 2 percent of private psychiatric visits.

Advances in medical knowledge have blurred many of the distinctions between mental and physical illness. People with untreated mental illness require significantly more care for ulcers, hypertension, malnutrition and other physical ailments. An estimated 20 to 30 percent of seniors who are labelled "senile" actually have reversible physical conditions that could, if recognized, be treated, restoring their health, independence, and dignity. Clearly, a health program that pays little or no attention to mental health is neither prudent nor effective. The wide disparity in Medicare coverage of physical and mental illness can no longer be justified.

This year, I sense a great resolve in Congress to do something about it. As you know, the Ways and Means Committee has voted to increase the Medicare outpatient mental health benefit from $250 to $1000. The Energy and Commerce Committee has refined our change, indexing the $1000 limit to the Medical Economic Index and exempting medical management services. Several proposals, including your own, Mr. Chairman, have been discussed in your Committee, and I expect you will discuss a few other ideas today. Whatever action you take, you cannot help but improve an otherwise inadequate benefit. Inaction, however, is risky.

We face a difficult reconciliation this year, with some tough choices for Medicare. Our target for Medicare cuts is now somewhere between $8.2 and 11.1 billion over three years. During reconciliation, it will not be easy to enact a meaningful increase in the mental health benefit. It makes much more sense to address this need today, when we have the option of financing the benefit through the Part B premium, the graduated premium, or some combination of the two -- just as we all have done in the areas of home health, hospice care, and skilled nursing care.

Inertia is a powerful force in politics and, unfortunately, often characteristic of the Medicare program. It is always tempting to put off change for a later opportunity. The opportunities for improving the elderly's mental health care have been few and infrequent. Thanks to you and your colleagues, Mr. Chairman, we face one today. I want to commend you again for your leadership, and pledge my help in your endeavors to create a meaningful mental health benefit for our senior citizens.

Senator MITCHELL. Are there any questions of any of the Representatives? Senator Durenberger?

Senator DURENBERGER. Just a comment and in the form of a question since this issue has been considered on the House side. We made the observation earlier in the morning as we were dealing with the recommendations on the drug benefit that this is a legitimate part of the consideration of catastrophic health insurance. Catastrophic is a new benefit. But when we begin to define "catastrophic," we do it in financial terms, and we overhear have settled on $1700.00. Then we have to add to that by way of definition out of pocket expenses for covered benefits. And at that point we get into the definition of "covered benefit".

And with regard to drugs and with regard to mental health, we are already talking about covered benefit.

It is not a matter of designing a new benefit like catastrophic and putting it into the program. It is taking the definition of "catastrophic" and relating it to two existing benefits. And while I have somewhat different feelings about how to approach the drug benefit and how to approach the mental health benefit, I can look at them and say if you are in a hospital where you need a doctor to inject a drug, you can get covered. But if you are not in a hospital, or you do not have a doctor or a nurse to inject the drug, you are not covered. Well that does not make a lot of sense. But I am open to looking at the drug.

The same thing happens with regard to mental health. The inconsistency of looking at the way this program existed in 1965, and putting it against the reality of 1987, and all of the changes that have taken place, and all the knowledge that we now have about the impact of mental health on society, and the treatment modes we have, and the drugs, I mean all of this stuff, I say we are not adding benefit. We are just trying to make existing benefits more realistic. And yet you always hear that, no, we can't expect to expand the benefit. Is that a problem when you have worked on this over on the House side, too? Is this the right logic to approach this whole catastrophic issue with? It doesn't seem at all with the Administration.

Congressman DOWNEY. I think that I follow your logic pretty clearly that the way we approached it in the House—and Sandy and Bill are on the subcommittee; I am not, but I tracked it pretty closely—was that this is a problem that we have had for the last 22 years that we have not dealt with. And now we have an opportunity to deal with it, so let's deal with it.

There are rational connections between mental health problems and catastrophic coverage that themselves would allow us to bootstrap this issue on top of that. But even if you did not have that potential connection, here is a covered benefit, as you suggest, that is not covering anybody properly. And now we have the chance to do it. Let's do it. And I think that that is somewhat compelling logic, given the fact that the next few years of what we will deal with in Medicare is simply trying to save money as opposed to deal with any additional benefits. So this is the time.

Congressman LEVIN. And let me just add, it is a greatest shortcoming. And when we are addressing seriously Medicare, do you leave it out? And, second, as Congressman Coyne and I originally

drafted it, we had it included within the calculation of catastrophic. And then it turned out that the Congressional Budget Office had not calculated it correctly. And then it was argued, when they re-calculated, that it would be too expensive.

And so we were caught. And I think, on balance, what makes sense is to broaden the coverage so that it keeps somewhat up to date, and then take another look after we have experience with it in terms of its inclusion within the calculation of a catastrophic bill that passes here.

But the worst thing to do is nothing. It shouldn't be caught between two posts, the catastrophic bill and the way it is today.

Senator DURENBERGER. Thank you, gentlemen.

Senator MITCHELL. Thank you very much.

Senator Matsunaga?

Senator MATSUNAGA. Thank you, Mr, Chairman.

First of all, let me thank you for scheduling this hearing on such short notice. I appreciate it very much, as a sponsor of the bill, S. 718, which is a similar measure to that introduced by Congressman Downey. I understand you have 60 cosponsors. I congratulate all three of you for appearing before this subcommittee. I might, at the outset, say you should not be disturbed too much by the Senate's strict adherence to seniority because when I was a freshman member in the House, I joined that group of freshman members and the junior Congressmen to overthrow the seniority system in the House. But seniority is a funny thing. The longer you stay in Congress, the more merit it begins to show. [Laughter.]

Congressman LEVIN. Congressman Downey agrees with you. [Laughter.]

Senator MATSUNAGA. But let me ask this. As I understand it, the Ways and Means Committee bill has a provision to raise the $250 cap to $1,000. Am I correct?

Congressman LEVIN. That is correct.

Senator MATSUNAGA. I had proposed to offer that amendment in the Finance Committee markup session. However, because of this promised hearing, I withheld it in the hope that we would go into other aspects of Congressman Downey's bill and mine. So I thank you for appearing before this subcommittee.

Congressman DOWNEY. Sparky, let me just say that the 62 sponsors are as a result of your still having a lot of friends in the House of Representatives more than anything else.

Senator MATSUNAGA. Thank you.

Congressman LEVIN. And if I just might add the hope of all of us that mental health not be left for bargaining between the House and the Senate. I understand the need for bargaining. I don't think this mental health need should be part of that process on balance.

Senator MITCHELL. Thank you very much, gentlemen. I know I speak for the other committee members when I say we are much impressed with your commitment and your effort in this area and we hope to work with you on it. Thank you.

The next witness is Dr. Robert Helms, the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. Dr. Helms, welcome, and we look forward to hearing from you.

STATEMENT OF ROBERT HELMS, Ph.D., ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC, ACCOMPANIED BY, ROBERT E. WREN, DIRECTOR OF THE OFFICE OF COVERAGE POLICY IN THE HEALTH CARE FINANCING ADMINISTRATION

Dr. HELMS. Thank you very much, Mr. Chairman. It is good to be back.

With me is Mr. Robert Wren, who is the Director of the Office of Coverage Policy in the Health Care Financing Administration.

I am pleased to be here today to discuss the proposed changes that you are considering in the basic Medicare outpatient mental health benefit package to be included in the catastrophic legislation.

The Administration strongly believes that this legislation should provide acute care, catastrophic protection for the elderly. Expansions to Medicare unrelated to acute care, catastrophic protection should not be included in the catastrophic bill.

The Administration conveyed to the House that the inclusion of Medicare program add-ons in the catastrophic bill would lead to a veto recommendation by the President's senior advisors. I understand that Mr. Docksai has already submitted this for the record. If not, I will be glad to.

The Administration's position is that the inclusion of expanded outpatient mental health benefit is regarded as a Medicare add-on, and would result in a similar recommendation.

The catastrophic legislation proposed by the Administration already addresses the problem of acute catastrophic psychiatric episodes. Coverage of acute episodes in general hospitals as well as the associated physician services are covered in the same manner as medical disorders. This approach of covering acute care is consistent with the nature of the Medicare program and the objective of the Administration's catastrophic initiative.

The Administration's plan was designed to provide peace of mind to all beneficiaries for a modest premium. Under this premium approach, the actuaries could accurately reconcile revenue and expenses, allowing the program to remain self-financing and budget neutral.

This approach, self-financing for an acute care catastrophic benefit, is quite different from an expansion of the underlying basic coverage which would be supported in large measure by general revenues.

Growth in Medicare Part B costs for the current program is already a problem. So the message is clear: If we are already concerned about paying for current benefits, then we need to be very careful about examining expansions to these benefits.

If Congress thinks an expansion of the basic outpatient mental health benefit is necessary, that debate should be undertaken separately from the debate on catastrophic. This expansion needs to be considered in the proper context of all Medicare benefits, and whether the limited benefit that accrues from this particular expansion would merit the adverse effect on the financial status of the entire Medicare program.

Based on our experience to date, the overwhelming majority—nearly 90 percent—of the approximately 560,000 beneficiaries who annually use the ambulatory psychiatric benefit do not reach the current limit. In addition, 70 percent of the users incur charges that are at or below 40 percent of the current limit.

Before a decision is made about an outpatient mental health benefit expansion, we urge you to consider these facts:

Utilization data indicate that the current limit is reached by very few beneficiaries;

We know that disabled Medicare beneficiaries are disproportionately represented among the users of mental health benefit, with many of these individuals probably being chronically mentally ill;

Because of the role of the States in caring for the mentally ill, it is not clear that a Medicare benefit change would enhance service provision, even for the limited number of beneficiaries on whom it might impact. Instead, we believe it might merely change the source of payment from the States to the federal government;

The Federal Government already provides separate block grant assistance at the rate of approximately $500 million for these State efforts;

The catastrophic legislation proposed by the Administration, as well as other bills introduced in the Congress, address the problem of acute catastrophic psychiatric episodes through coverage of general hospitalization and the services of physicians provided to inpatients.

We believe these facts are compelling: expansion of the Medicare ambulatory mental health benefit needs to be considered within the framework of other chronic disease needs that fall within long-term care.

We recognize that the existing ambulatory mental health benefit has not been examined since the inception of the program, and that advances in the treatment of psychiatric disorders have resulted in changes in the way care is given. However, based on a number of facts, some of which I have outlined here, we believe that considerably more thought and study needs to be given to the issue.

Again, the bottom line is that even if Congress thinks such an expansion of basic benefits needs to be considered, that debate should be undertaken separately from the debate on catastrophic. Its inclusion in a catastrophic bill would subject that bill to a veto recommendation.

Mr. Chairman, that concludes my statement. I would be happy to try to answer any questions.

Senator MITCHELL. Thank you very much, Dr. Helms.

Senator Durenberger?

Senator DURENBERGER. No questions, Mr. Chairman.

Senator MITCHELL. Senator Matsunaga?

Senator MATSUNAGA. Dr. Helms, you state that utilization data indicate that the current limit is reached by very few beneficiaries. Now is it not true that because of the outpatient "cap" now having a dollar value of $57.00, since it has not been raised since 1965, the elderly who are truly in need of mental care just refuse to do so for fear that they will be subjected to high out-of-pocket costs?

Dr. HELMS. Let me say that we don't really think it is a financial reason. I would agree with you that the evidence seems to indicate that, the utilization of these services on an outpatient basis is low, as you say. The utilization among the aged seems to be lower than among the general population for these kinds of services. I think that rather than financial, it has to do with long-held attitudes about using psychiatric services. That is something that the Department is very interested in. Because the elderly seem to be reluctant about seeking psychiatric services the Department has supported efforts, for example, to educate physicians about the availability of new types of drugs to treat psychiatric disorders.

Given that so many people do not really come up to the cap already, I have a hard time believing that it is mainly a financial constraint.

Senator MATSUNAGA. And is it not true also that because of the limitation, many physicians are actually treating mental disorders as physical disorders intentionally and mistakenly?

Dr. HELMS. That may be partially true. I would like to point out that in Part B, in 1985, 180 million was spent, and on the inpatient side in just the PPS hospitals, in the DRGs, 424 through 434, for mental disorders, about $1.3 billion was paid for beneficiaries' with mental disorders.

There may be some of that. But, again, the inpatient procedures on the DRG system now are subject to much tighter and, I think, higher quality peer review to look at this. So you may be getting some of that. I would agree that the incentives are there to do it.

Senator MATSUNAGA. According to the statistics presented to me by experts, the percentage of beneficiaries who use the out patient mental health benefit and exceed the limit is now about 11 percent, up from 5 percent a decade ago. Isn't that correct?

Dr. HELMS. I'm sorry. You are saying that 11 percent?

Senator MATSUNAGA. That's right. That the percentage of beneficiaries who use the benefit and exceed the limit—exceeds the limit by 11 percent as compared to 5 percent a decade ago.

Dr. HELMS. I think that is approximately right.

Senator MATSUNAGA. So there is definitely an indication of need for raising the cap, is there not?

Dr. HELMS. Yes there are, a few individuals. A lot of those, we think, are probably people who are disabled because of chronic mental problems.

Senator MATSUNAGA. Well it appears to me that is awful.

Dr. HELMS. Again, not so much the aged. That is the best indication we have.

Senator MATSUNAGA. It appears to me that in your position you have to take the position you are taking, despite what the best policy may be, so—

Dr. HELMS. Let me point out that when we had the H.H.S. advisory committee on catastrophic health costs we looked at this. We really think that most of the acute catastrophic situations in mental illness are handled on the inpatient side. And if you do go back to the Bowen proposal it would add a much better catastrophic benefit for those situations. And we think that we have taken care of this for the vast majority of catastrophic cases.

Senator MATSUNAGA. Thank you. No further questions, Mr. Chairman.

Senator MITCHELL. Thank you very much, Senator Matsunaga.

Senator Bentsen, the Chairman of the full Committee, had intended to be at this hearing but has been called away by other pressing business. He is going to try to get back before the hearing is over. I know he is vitally interested in this subject.

Thank you very much, Dr. Helms. We appreciate your testimony and we look forward to working with you in the future.

Dr. HELMS. Thank you.

Senator MITCHELL. And the final panel will consist of four witness: Steven Sharfstein, former Deputy Medical Director of the American Psychiatric Association; Ann Utley, Member of the National Board of the National Mental Health Association; Malcolm Strickler, Administration, Friends Hospital, Philadelphia, Pennsylvania, on behalf of the National Association of Private Psychiatric Hospitals; and Alan Spielman, Executive Director, Government Programs-Legislation, Blue Cross and Blue Shield Association.

Good afternoon, Miss Utley, and gentlemen. We look forward to hearing from you. We will begin with Dr. Sharfstein.

[The prepared written statement of Dr. Helms follows:]

STATEMENT BY

ROBERT B. HELMS, PH.D
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
UNITED STATES SENATE

JUNE 18, 1987

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE,
I AM PLEASED TO BE HERE TODAY TO DISCUSS WITH YOU PROPOSED CHANGES TO THE BASIC MEDICARE OUTPATIENT MENTAL HEALTH BENEFIT PACKAGE THAT ARE BEING CONSIDERED FOR INCLUSION IN THE CATASTROPHIC LEGISLATION.

THE ADMINISTRATION STRONGLY BELIEVES THAT THIS LEGISLATION SHOULD PROVIDE ACUTE CARE, CATASTROPHIC PROTECTION FOR THE ELDERLY. EXPANSIONS TO MEDICARE UNRELATED TO ACUTE CARE, CATASTROPHIC PROTECTION SHOULD NOT BE INCLUDED IN A CATASTROPHIC BILL. THE ADMINISTRATION CONVEYED TO THE HOUSE THAT INCLUSION OF MEDICARE PROGRAM ADD-ONS IN A CATASTROPHIC BILL WOULD LEAD TO A VETO RECOMMENDATION BY THE PRESIDENT'S SENIOR ADVISORS. I HAVE BEEN ADVISED THAT THE INCLUSION OF AN EXPANDED OUTPATIENT MENTAL HEALTH BENEFIT IS REGARDED AS A MEDICARE ADD-ON AND WOULD RESULT IN A SIMILAR RECOMMENDATION.

THE CATASTROPHIC LEGISLATION PROPOSED BY THE ADMINISTRATION ALREADY ADDRESSES THE PROBLEM OF ACUTE CATASTROPHIC PSYCHIATRIC EPISODES. COVERAGE OF ACUTE EPISODES IN GENERAL HOSPITALS AS WELL AS THE ASSOCIATED PHYSICIAN SERVICES ARE COVERED IN THE SAME MANNER AS MEDICAL DISORDERS. THIS APPROACH OF COVERING ACUTE CARE IS CONSISTENT WITH THE NATURE OF THE MEDICARE PROGRAM AND THE OBJECTIVE OF THE ADMINISTRATION'S CATASTROPHIC INITIATIVE.

THE ADMINISTRATION'S PLAN WAS DESIGNED TO PROVIDE PEACE OF MIND TO ALL BENEFICIARIES FOR A MODEST PREMIUM. UNDER THIS PREMIUM APPROACH, THE ACTUARIES COULD ACCURATELY RECONCILE REVENUE AND EXPENSES -- ALLOWING THE PROGRAM TO REMAIN SELF-FINANCED AND BUDGET NEUTRAL.

THIS APPROACH, SELF-FINANCING OF AN ACUTE CARE CATASTROPHIC BENEFIT, IS QUITE DIFFERENT FROM AN EXPANSION OF THE UNDERLYING BASIC COVERAGE WHICH WOULD BE SUPPORTED IN LARGE MEASURE BY GENERAL REVENUES. GROWTH IN MEDICARE PART B COSTS FOR THE CURRENT PROGRAM IS ALREADY A PROBLEM. THE MESSAGE IS CLEAR: IF WE ALREADY ARE CONCERNED ABOUT PAYING FOR CURRENT BENEFITS, THEN WE NEED TO CAREFULLY EXAMINE EXPANSIONS SUCH AS THOSE UNDER CONSIDERATION HERE TODAY.

IF CONGRESS THINKS AN EXPANSION OF THE BASIC OUTPATIENT MENTAL HEALTH BENEFIT IS NECESSARY, THAT DEBATE SHOULD BE UNDERTAKEN SEPARATELY FROM THE DEBATE ON CATASTROPHIC. THIS EXPANSION NEEDS TO BE CONSIDERED IN THE PROPER CONTEXT OF ALL MEDICARE BENEFITS, AND WHETHER THE LIMITED BENEFIT THAT ACCRUES FROM THIS PARTICULAR EXPANSION WOULD MERIT THE ADVERSE IMPACT ON THE FINANCIAL STATUS OF THE ENTIRE MEDICARE PROGRAM.

BASED ON OUR EXPERIENCE TO DATE, THE OVERWHELMING MAJORITY (NEARLY 90 PERCENT) OF THE APPROXIMATELY 560,000 BENEFICIARIES ANNUALLY USING THE AMBULATORY PSYCHIATRIC BENEFIT DO NOT REACH

THE CURRENT LIMIT. IN ADDITION 70 PERCENT OF THE USERS INCUR CHARGES AT OR BELOW 40 PERCENT OF THE CURRENT LIMIT.

CONSEQUENTLY, WE MUST QUESTION WHETHER AN EXPANSION OF THE OUTPATIENT MENTAL HEALTH BENEFIT, ALREADY ADEQUATELY COVERING THE NEEDS OF THE VAST MAJORITY OF BENEFICIARIES, IS NECESSARY OR APPROPRIATE. IS IT OF HIGHER PRIORITY THAN ASSURING OUR ABILITY TO PAY FOR THE CURRENT BENEFIT PACKAGE? IS IT MORE IMPORTANT THAN OTHER AREAS OF NEED? FOR EXAMPLE, LEGISLATION UNDER CONSIDERATION IN THE HOUSE WOULD INCREASE THE CURRENT PROGRAM PAYOUT LIMIT OF $250 TO $1000. ACCORDING TO THE CONGRESSIONAL BUDGET OFFICE, THIS PROVISION ALONE IS ESTIMATED ANNUALLY TO COST $85 MILLION IN 1989 AND $335 MILLION BY 1992.

BEFORE ANY DECISION IS MADE ABOUT AN OUTPATIENT MENTAL HEALTH BENEFIT EXPANSION WE URGE YOU TO CONSIDER THESE FACTS:

- UTILIZATION DATA INDICATE THAT THE CURRENT LIMIT IS REACHED BY VERY FEW BENEFICIARIES.

- WE KNOW THAT DISABLED MEDICARE BENEFICIARIES ARE DISPROPORTIONATELY REPRESENTED AMONG THE USERS OF THE MENTAL HEALTH BENEFIT, WITH MANY OF THESE INDIVIDUALS PROBABLY BEING CHRONICALLY MENTALLY ILL.

- BECAUSE OF THE ROLE OF THE STATES IN CARING FOR THE MENTALLY ILL, IT IS NOT CLEAR THAT A MEDICARE BENEFIT CHANGE WOULD ENHANCE SERVICE PROVISION -- EVEN FOR THE LIMITED NUMBER OF BENEFICIARIES ON WHOM IT MIGHT IMPACT. INSTEAD WE BELIEVE IT MIGHT MERELY CHANGE THE PAYMENT SOURCE.

- THE FEDERAL GOVERNMENT ALREADY PROVIDES SEPARATE BLOCK GRANT ASSISTANCE (APPROXIMATELY $500 MILLION IN FY 1987) IN SUPPORT OF THESE STATE EFFORTS.

- THE CATASTROPHIC LEGISLATION PROPOSED BY THE ADMINISTRATION, AS WELL AS OTHER BILLS INTRODUCED IN THE CONGRESS, ADDRESS THE PROBLEM OF ACUTE CATASTROPHIC PSYCHIATRIC EPISODES THROUGH COVERAGE OF GENERAL HOSPITALIZATION AND THE SERVICES OF PHYSICIANS PROVIDED TO INPATIENTS.

WE BELIEVE THESE FACTS ARE COMPELLING: EXPANSION OF THE MEDICARE AMBULATORY MENTAL HEALTH BENEFIT NEEDS TO BE CONSIDERED WITHIN THE FRAMEWORK OF OTHER CHRONIC DISEASE NEEDS THAT FALL WITHIN LONG-TERM CARE.

WE RECOGNIZE THAT THE EXISTING AMBULATORY MENTAL HEALTH BENEFIT HAS NOT BEEN EXAMINED SINCE THE INCEPTION OF THE PROGRAM, AND THAT ADVANCES IN THE TREATMENT OF PSYCHIATRIC DISORDERS HAVE

RESULTED IN CHANGES IN THE WAY CARE IS GIVEN. HOWEVER, BASED ON A NUMBER OF FACTS, SOME OF WHICH I HAVE OUTLINED HERE, WE BELIEVE THAT CONSIDERABLY MORE THOUGHT AND STUDY NEEDS TO BE GIVEN TO THE ISSUE. IS SIMPLY RAISING THE LIMIT TO $1000 THE BEST WAY TO GO, IF ANY EXPANSION TO THE CURRENT MEDICARE OUTPATIENT MENTAL HEALTH BENEFIT PACKAGE IS WARRANTED?

WE NEED TO EXAMINE IMPORTANT QUESTIONS SUCH AS THE FOLLOWING:

- GIVEN THE PATTERN OF UTILIZATION, MOST USERS ARE NOT IN NEED OF ACUTE CARE AND FIND THE BENEFIT ADEQUATE. IS INCREASING EXPENDITURES FOR THIS BENEFIT TO A VERY LIMITED NUMBER OF INDIVIDUALS REASONABLE? ARE PROBABLE COSTS AND BENEFITS COMMENSURATE?

- GIVEN STATE ACTIVITIES IN THE CARE OF THE MENTALLY ILL, WOULD SUCH A BENEFIT EXPANSION RESULT IN ENHANCED SERVICES FOR MEDICARE BENEFICIARIES? OR WOULD IT MERELY CHANGE A CHRONIC CARE EXPENSE FROM STATE BUDGETS TO THE FEDERAL BUDGET?

AGAIN, THE BOTTOM LINE IS THAT EVEN IF CONGRESS THINKS SUCH AN EXPANSION OF BASIC BENEFITS NEEDS TO BE CONSIDERED, THAT DEBATE SHOULD BE UNDERTAKEN SEPARATELY FROM THE DEBATE ON CATASTROPHIC. ITS INCLUSION IN A CATASTROPHIC BILL WILL SUBJECT THAT BILL TO A VETO RECOMMENDATION.

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MR. CHAIRMAN, THAT CONCLUDES MY STATEMENT. I SHALL BE HAPPY NOW TO ADDRESS ANY QUESTIONS YOU OR OTHER MEMBERS OF THE SUBCOMMITTEE MIGHT HAVE.

STATEMENT OF STEVEN SHARFSTEIN, M.D., FORMER DEPUTY MEDICAL DIRECTOR, AMERICAN PSYCHIATRIC ASSOCIATION, BALTIMORE, MD

Dr. SHARFSTEIN. Thank you, Mr. Chairman.

Mr. Chairman and distinguished Senators, I am Steven Sharfstein, Medical Director of the Shepherd and Enoch Pratt Psychiatric Hospital in Baltimore and Clinical Professor of Psychiatry at the University of Maryland. Formerly, I was Deputy Medical Director of the American Psychiatric Association and was involved for 13 years in the Public Health Service in policy and health financing at the National Institute of Mental Health.

In addition to the practice of psychiatry, my career has been devoted to health financing and services research. I have published over a hundred papers and books on this subject.

I am honored to appear before the Senate Finance Committee's Health Subcommittee on behalf of the American Psychiatric Association, a medical specialty society representing more than 33,000 physicians nationwide.

My full testimony you have for the record. My oral statement will focus on three areas: structuring a benefit for catastrophic health insurance purposes, which could serve as an initial step on the legislative journey toward a cost effective redirection of the Medicare program's treatment of patients with mental and addictive disorders, and how one might look at restructuring the totality of the Medicare psychiatric benefit for those with mental and addictive disorders. And then I would like to make some comments about clinical mental illness.

As we have previously testified before this subcommittee, the APA supports the concept of nondiscriminatory coverage for patients with mental and addictive disorders. If due to budgetary constraints nondiscriminatory coverage is not possible, presently APA's recommendations focus on a proposed outpatient mental health floor amendment for S. 1127 and the need to eliminate the 190-day lifetime limit in psychiatric hospitals.

I cannot even begin to address our particular concern without first expressing our deep appreciation for the interest evidenced by this committee and by the three distinguished Senators who have offered amendments during the markup of S. 1127 and many other Senators who have commented publicly on the need to change these outmoded and outdated benefits.

As you have heard, the House Ways and Means Committee and the Health and Environment Subcommittee of Energy and Commerce have included very important modifications and we commend them for their efforts as well.

As you know, for outpatient mental health care Medicare limits coverage for treatment is now $250.00 after an effective 50 percent copayment, and this benefit has not changed since the inception of the program, and has not kept pace with inflation, and, therefore, effectively we have a slashed benefit.

Senator Matsunaga has introduced the Medicare Mental Illness Nondiscrimination Act of 1987 which eliminates discriminatory coverage of outpatient mental disorders treatment.

Senator Durenberger has introduced The Medicare Ambulatory Mental Health Services Access Amendments of 1987, and you, Mr. Chairman, have drafted an amendment prior to the Catastrophic Health Insurance markup.

For those with mental and addictive disorders, the current outpatient benefit is indeed catastrophic for them. This benefit is so limited as to encourage patients either to spend a great deal of money out of pocket for outpatient care or to more often use inpatient services or to wait until a true catastrophe sets in. The science and understanding of treating mental illness has progressed, and management of these disorders using combinations of psychopharmocologic agents and other modes of treatment has also progressed.

Dr. Helms does not understand the nature of chronic mental illness. Chronic mental illness, similar to chronic medical illness, has acute episodes that are acutely catastrophic. It is a relapsing illness, similar to diabetes and arthritis. The capacity to have outpatient benefits that are adequate, in fact, is an acute catastrophic benefit.

Despite the fact that some treatments mentally ill patients use are comparable to those used for any patient who may have a chronic medical illness, the monitoring of medications and other medical interventions is subject to the arbitrary $250.00 limit.

APA recommends for the committee a Senate floor amendment to the catastrophic health insurance bill: first, the exemption of medical management of mental and addictive disorders from any limits which may be imposed on psychotherapy; second, 25 outpatient psychotherapy visits or the $1,000.00 limit annually with appropriate peer review mechanisms if these are thought to be needed; and, third, include all unfunded expenditures on covered outpatient services in the cap that triggers a catastrophic expenditure.

I would like to close by mentioning a patient that I recently admitted to the Shepherd Pratt Hospital, a 73 year old lady with an acutely psychotic manic illness. At the time of her admission, she had some gross delusions and was very difficult to understand. But one thing came across crystally clear. She wanted to know whether her Medicare benefits would cover her illness. She wanted to know not only in terms of her stay in the hospital, but also in terms of needed outpatient care. And I was struck with the fact that adding to the tragedy of mental illness was the worry of a potential financial catastrophy. It is very important that you do something about this now.

Thank you very much.

Senator MITCHELL. Thank you Dr. Sharfstein.

Miss Utley?

[The prepared written statement of Dr. Sharfstein follows:]

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TESTIMONY OF

THE AMERICAN PSYCHIATRIC ASSOCIATION

BEFORE THE

SENATE FINANCE HEALTH SUBCOMMITTEE

ON

THE MEDICARE PROGRAM AND COVERAGE FOR

THE MENTALLY ILL

JUNE 18, 1987

PRESENTED BY

STEVEN SHARFSTEIN, M.D.

Mr. Chairman and distinguished Senators, I am Steven S. Sharfstein, M.D., Medical Director of the Shepherd and Enoch Pratt Psychiatric Hospital in Baltimore and Clinical Professor of Psychiatry at the University of Maryland. Formerly, I was Deputy Medical Director of the American Psychiatric Association and was involved in policy and health financing at the National Institute of Mental Health. In addition to the practice of psychiatry much of my career has been devoted to health financing and services research. I am honored to appear before the Senate Finance Health Subcommittee on behalf of the American Psychiatric Association, a medical specialty society representing more than 33,000 physicians nationwide.

Introduction

My testimony today, as requested by Committee staff, will not reiterate APA's previously expressed concerns to Congress about the catastrophic health insurance needs of the mentally ill and the documentation of cost effectiveness of mental health care. Concerns about the catastrophic health insurance needs of the mentally ill were presented before the Senate Finance Committee on March 19, 1987 when we testified together with the National Alliance for the Mentally Ill and the National Association of Private Psychiatric Hospitals. As you know APA supports the concept of nondiscriminatory coverage for patients with mental and addictive disorders.

Our testimony today will focus on two major areas: how a benefit can be structured for catastrophic health insurance purposes and thus serve as an initial step on the legislative journey toward a cost effective redirection of the Medicare program's treatment of mental and addictive disorders; and, how one might look at restructuring the totality of the Medicare psychiatric

benefit for those with mental disorders. Three distinguished Senators, including you, Mr. Chairman, have been quite concerned about restructuring Medicare's outpatient psychiatric benefit. I will take this opportunity to first comment on those bills and proposed amendments and then elaborate on how these would help meet the catastrophic mental health needs of the population we are here to discuss.

However, I cannot even begin to address any of the particular legislative matters without first expressing our deep appreciation for the interest and concern by this Committee in beginning the legislative journey to eliminate Medicare's historic discriminatory coverage for the treatment of mental illness. A number of your distinguished House Ways and Means and Energy and Commerce Committee colleagues (Representatives Downey, Coyne, Levin and Sikorski), with the support of their respective Committee and Subcommittee leadership, have proposed through H.R. 2470 to respond to the catastrophic nature of physical and mental illness by readjusting Medicare's psychiatric outpatient benefit which concommitantly will have a cost-effective impact on the catastrophic inpatient segment. The House Ways and Means bill adjusts Medicare's outpatient mental health benefit to current dollars (with Medicare paying $1,000). The effective 50% copayment is left intact. APA appreciates this effort on behalf of our patients and further commends the House Energy and Commerce Subcommittee on Health and the Environment for changing this benefit by exempting medical management of mental disorders from any limits and allowing 25 psychotherapy visits.

Current Outpatient Proposals

Medicare's current coverage policy limits outpatient mental health care to $250 annually after an effective 50% copayment. Many Senators on the Finance Committee have recognized the inadequacy of this benefit and have commented on the need to at least adjust the benefit for inflation. In fact, the Chairman of the Finance Committee, Senator Bentsen and other distinguished Senators noted the limitation of the mental health benefit when S. 1127 was introduced.

At this juncture we will comment on three recent bills or proposed amendments to begin to change Medicare's discriminatory coverage of the treatment of mental illness. All proposals respond to changes in the new science of treatment of mental illness.

First, Senator Matsunaga in March of this year introduced the Medicare Mental Illness Nondiscrimination Act of 1987, S. 718. This bill would eliminate Medicare's discriminatory limits on outpatient psychiatric care and thus, where appropriate, encourage physicians and patients to use less expensive outpatient care as a viable alternative to inpatient care. The bill would provide nondiscriminatory outpatient coverage for those with mental and addictive disorders. By including portions of this bill in a catastrophic health insurance bill, as has been done by the House Ways and Means and Energy and Commerce Committees, the Congress could not only ease the burden for those who now need medically necessary outpatient psychiatric care and may have reduced access to this care, but also permit a cost offset to inpatient catastrophic expenditures.

Second, in May Senator Durenberger introduced "The Medicare Ambulatory Mental Health Services Access Amendments of 1987," (S. 1209). This

bill would consider medical management of psychiatric disorders in the same manner that physical illness is covered under Medicare. Limits are placed solely on one particular facet of psychiatric treatment, psychotherapy (with a system of varying copayment mechanisms).

Precedent already exists for this separation of medical management and psychotherapy. In 1984 the Department of HHS (Health and Human Services) implemented a Medicare coverage change for one category of treatment of mental, psychoneurotic and personality disorders that is, Alzheimer's Disease and related disorders. It removed limitations on medical management but maintained the effective $250 limit on psychotherapy. The coverage change recognizes that the care of patients with Alzheimer's Disease and Related Disorders is essentially medical in nature. As you well know, for those with chronic or acute mental illness, treatment may involve psychopharmacological intervention in conjunction with or instead of psychotherapy. As with any illness of a chronic or acute nature treated by a physician, when medication is prescribed there may be need for monitoring of blood levels, urinary function and blood pressure. The assessment of these functions bears particular import in the elderly population who on average take ten medications per person. At times the medications they take for high blood pressure (such as beta blockers) may produce severe depressions. These depressions may be alleviated by change or reworking of the multiplicity of medications in conjunction with other physicians. The elderly with mental disorders include first those who reach old age with a history of chronic mental impairment. Second, those with no history of mental impairment who develop one in older age, and third those with physical and mental disorders. With current coverage, some of our sickest patients, (for instance, those who suffer from manic depression and schizophrenia and may

need this type of medical management intervention, and those with physical and mental disorders), have the essentially medical portion of any of their interventions or treatments subject to an arbitrary discriminatory outpatient limit. We anticipate that between one third and one half of the patients who currently receive mental health outpatient services could benefit from the medical management coverage change.

How could a medical management benefit work? Let us look at the disease of manic depression. This disorder has been effectively treated for many years by a drug called lithium. (I might note that parenthetically it has been well documented by research that such treatment has resulted in saving of $6.5 billion dollars cost saving over the past decade.) This pharmacological agent, like others, must be carefully monitored. Some individuals function in a well-calibrated manner, and need rare intervention, others, however, need such more careful monitoring. When we speak about manic depressive disorders, we speak of a genetically based disease with physiological concomitants not the ups and downs of everyday life. A recent Newsweek article documented the identification of a specific gene as a cause of manic-depression. Separate teams have identified a protein that appears to be specific to the brains of patient with Alzheimer's disease. These discoveries herald a new era in the application of genetics to psychiatric disorders. Schizophrenia is another complex disease with a physiological basis, onset in early life and long-term treatment needs.

With respect to use of psychotherapy, Senator Durenberger's bill, while a commendable concept, may pose some difficulties administratively because of the varying copayments depending on the number of psychotherapy visits. Alternatively, in lieu of varying copayments to impact upon utilization, one may wish to implement a peer review mechanism. APA has been

extensively involved through our own quality assurance group in assisting CHAMPUS and third party insurers to provide quality, cost effective mental health services by implementing appropriate peer review.

Your own draft amendment Senator Mitchell attempted to identify the sickest patients by disease and include only those individuals in catastrophic proposals. When I was at National Institute of Mental Health my colleagues and I investigated this approach but it may be problematic for a number of reasons. First, the majority of other patients covered by catastrophic proposals or bills are defined as being in the catastrophic category because they have catastrophic expenditures. Second, this would place the patient at financial risk. If a patient is found to have a disorder not covered by the catastrophic plan then they will be at risk for all out-of-pocket expenditures. Third, this may be easy to "game" as some individuals might automatically classify patients in these categories.

Who currently uses outpatient mental health care? According to a recent CBO estimate based on the Medicare statistical file, in 1985 approximately 465,000 Medicare beneficiaries used outpatient mental health services and approximately 10 percent of those individuals had claims near or at the $250 dollar limit. This would translate into approximately $101 dollars per user. Other HCFA data estimates that in 1975 4.9 percent of the approximately 170,000 Medicare beneficiaries who used mental health outpatient services submitted bills for more than $500 dollars worth of services (and were thus affected by the limit) whereas .03 percent of all Medicare beneficiaries were affected by the limit. (The numbers of total individuals using services differ because of the methods used in collecting the two data sources. The following estimate of beneficiaries may include some for whom claims may not be paid in the future.) By 1986 estimates indicated that 11.2

percent of beneficiaries who used mental health services (approximately 560,306 beneficiaries) reached the $500 limit and .21 percent of all Medicare beneficiaries had reached the outpatient limitation. Thus, the limitations are affecting more and more of the population. There appears to be a trend toward more beneficiaries reaching the limitations at the same time that some individuals may be discouraged from using the benefit because it is so limited (a finding borne out by the Rand Health Insurance Experiment).

As you know, expenses incurred for services furnished by other health personnel in conjunction with "or incident to" a physician's treatment of mental, psychoneurotic or personality disorders are not subject to the $250 limit if the patient has not met this limit with psychiatrists' or treatment services. Once the beneficiary reaches the annual limit services are no longer paid. Thus additional services may be provided in a variety of settings incident to the psychiatrists services.

APA recommends (if nondiscriminatory coverage is not possible due to budgetary constraints) a catastrophic outpatient mental health floor amendment which exempts medical management from any caps which you may choose to impose on the psychotherapy benefit. If limits must be imposed on psychotherapy we recommend 25 visits. All incurred covered costs should be included in the cap that triggers a catastrophic expenditure. Let us ease the burden for our elderly and chronically mentally ill by beginning the legislative journey toward nondiscrimination.

Specifically, we have recommended the separation of outpatient medical management and psychotherapy with a 25 visit limit based on a review of the literature and actual experience. The TRIMS experiment and eventual service delivery in a community mental health center in Texas, indicated anecdotally that approximately 90% of geriatric patients with mental

disorders used less than 24 visits a year. Statistics from the private sector suggests that approximately 80% of patients can be treated within these limits. In 1973 psychiatrists' fees were $35 per hour of psychotherapy visit, if one assumes these fees were approximately $20 per hour in 1965 the average number of one hour psychotherapy visits would have been 25 (data from 1965 is not currently available).

Other Coverage Issues

The 190 day lifetime limit in psychiatric hospitals is outdated and outmoded. We are not talking of residential care we are referring to an active course of inpatient treatment as life saving as other medical and surgical interventions and treatment. APA has recommended eliminating discriminatory coverage policies for those with mental disorders in all programs. If this is not possible due to budgetary constraints, you may consider eliminating the "lifetime limit" and in lieu thereof imposing an annual limit (such as 75 days), with a peer review mechanism for additional medically necessary care on a case-by-case basis. APA also recommends a two for one tradeoff to allow partial hospitalizations programs to develop more fully.

It has been well documented that APA's own inpatient peer review program implemented for CHAMPUS saved close to approximately two million dollars in 1985 alone by disallowing 6,626 inpatient days. Hospital limits, even annual ones will be problematic, if the outpatient psychiatric benefit is not expanded to ensure nondiscriminatory medical management coverage and responsible outpatient psychotherapy limits. Currently all acute psychiatric episodes for elderly and chronically mentally ill patients must be

seen in a hospital. With expanded outpatient coverage some alternatives may exist.

Unpublished statistics suggest that approximately 60% of the patient population hospitalized for mental disorders are over age 65. Overall, approximately 70% of the Medicare population with mental disorders is over age 65.

If an annual limit were to be placed on care in an inpatient psychiatric hospital, partial hospitalization services would need to be provided more fully by the Medicare program, with appropriate prior certification and ongoing review of active treatment. These services could save funds for Medicare and provide needed help for beneficiaries. Estimates indicate that these programs cost about half of what an inpatient hospital day does.

Summary

APA supports nondiscriminatory coverage of mental and addictive disorders under Medicare. If at this time budget constraints will not allow such an appropriate and fair restructuring of Medicare's psychiatric benefit, we recommend:

(a) An outpatient mental health floor amendment to the catastrophic health insurance bill (S. 1127) which would:

1) Exempt medical management of mental and addictive disorders from limits otherwise imposed on psychotherapy.

2) Permit 25 psychotherapy visits annually.

3) Allow all unfunded covered services to trigger a catastrophic expenditure.

(b) Delete the 190 day lifetime limit on treatment in psychiatric hospitals. If an annual limit is imposed (e.g. 75 days) peer review should authorize additional medical treatment necessary on a case-by-case basis. In the event of an annual limit, authorize a tradeoff of two partial hospitalization days for every one inpatient day.

Let me end by quoting from a document published almost ten years ago which tragically is still appropriate today (by the then President's Commission on Mental Health (the Task Panel on Mental Health of the elderly)): . . ."Existing policies in Medicare specifically, have tended to foster inpatient psychiatric treatment without adequate support for outpatient, day care, or ongoing rehabilitative services . . . current limitations . . . have proven to be shortsighted, inequitable and costly. Inpatient health and mental health services are often used when outpatient mental health care would be more appropriate and less expensive . . . The availability of ambulatory or day care based mental health services has the potential for reversing developing disabilities and keeping them from becoming permanent. Yet unless there is an adequate source of funding for these services, their potential will remain unfulfilled."

STATEMENT OF ANN UTLEY, MEMBER OF THE NATIONAL BOARD, NATIONAL MENTAL HEALTH ASSOCIATION, DALLAS, TX, ACCOMPANIED BY CHRIS KOYANAGI, DIRECTOR OF FEDERAL RELATIONS FOR THE NATIONAL MENTAL HEALTH ASSOCIATION

Ms. UTLEY. Mr. Chairman and members of the committee, my name is Ann Utley. I am on the Board of the National Mental Health Association. I am also Vice President in charge of education and communication for the Mental Health Association in Texas. I would like to introduce to you Chris Koyanagi. She is the Director of Federal Relations for the National Mental Health Association.

Today, I would like to discuss with you the need to improve the Medicare coverage of mental health services. It certainly makes sense to consumers of mental health services because they are the major mental illnesses that very quickly become a tremendous financial disaster. And for anyone with a serious mental illness, Medicare provides such limited reimbursement for essential services that one quickly finds oneself with terrible out of pocket expenditures.

We, therefore, recommend that changes to Medicare mental health coverage be made and be made as quickly as possible.

Our highest priority is improvement in outpatient mental health benefits. We applaud efforts by members of this committee to address this need, such as S. 1209, introduced by Senator Durenberger—and, Senator Durenberger, I do bring you greetings from Patt Franciosi, and also thank you for your kind comments at our recent gala—and introduced by Senator Matsunaga, which was Senate bill 718.

Senator DURENBERGER. Thank you. Ms. Utley. We suggest the following outpatient mental health package:

One, coverage of routine physician visits for purposes of monitoring the patient's condition, particularly the monitoring of medications and their side effects, but specifically excluding psychotherapy on the same basis as any other physician visit for any other illness.

Coverage of psychotherapy for up to 25 visits per year;

The coverage of routine physician visits sometimes termed "medical management" removes a highly discriminatory restriction from the law, one that could also be potentially dangerous for patients on psychotropic medications. Currently, visits to physicians for medication monitoring fall within that $250 cap. By removing the cap from these visits, physicians could monitor potentially toxic medications without arbitrary limits which have no medical basis.

The other change that we urge would alter the limit on outpatient psychotherapy from a dollar limit to a visit limit of 25 visits per year.

According to CBO, 25 visits is an equivalent benefit of the $1,000 cap. It is now more than 20 years since that original $250 limit on psychiatric care was enacted and no adjustment, as you have heard today, has been made in that 20 years. And, again, I will repeat that 20 years ago that $250 today, 20 years later, is now worth that same $57 that we heard earlier.

A shift to a limit on visits avoids this problem in the future, and it is an approach increasingly being adopted by States as they regulate health insurance coverage for mental illness.

In addition to the changes in outpatient benefits described, we urge the following changes regarding Part A services:

One, the unlimited coverage of psychiatric services in a general hospital, which is now included in Senate bill 1127, should be changed to a 75-day-a-year limit for psychiatric services in both general hospitals and in psychiatric hospitals.

Two, coverage beyond that 75-day limit should then be provided if found necessary through a medical necessity review in the same manner that is done by the CHAMPUS program.

Three, that reimbursement of inpatient services should be made only for patients receiving active treatment.

Four, a new benefit of partial hospitalization services should be added with a trade-off of partial hospitalization services for each day of inpatient care under that 75-day limit, annual limit.

These proposed changes to Part A would eliminate the current 190-day limit on care in a psychiatric hospital and establish instead inpatient limit on psychiatric services in all settings. Such a limit further allows for a trade-off mechanism between 24-hour-a-day inpatient stays and partial hospitalization services. Partial hospitalization programs provide day services for patients who continue to live in the community, or evening and night services for patients who are able to leave the hospital during the day.

The costs of partial hospitalization, according to the data compiled by the National Institute of Mental Health, are generally about one-third as expensive as 24-hour-a-day inpatient stay.

Mr. Chairman, we would hope that as your committee goes on that you will continue to study this, and as quickly as possible, let's get some help for these people that really need it.

Thank you.

Senator MITCHELL. Thank you, Miss Utley.

Mr. Strickler.

[The prepared written statement of Ms. Utley follows:]

TESTIMONY SUBMITTED TO

COMMITTEE ON FINANCE
UNITED STATES SENATE

REGARDING

S 1127, S 1209, S 718
CATASTROPHIC HEALTH INSURANCE

BY

ANN UTLEY
MEMBER OF THE BOARD
NATIONAL MENTAL HEALTH ASSOCIATION

ON BEHALF OF

MENTAL HEALTH LAW PROJECT
NATIONAL ALLIANCE FOR THE MENTALLY ILL
NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS
NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS
NATIONAL MENTAL HEALTH ASSOCIATION

JUNE 18, 1987

Mr. Chairman, Members of the Committee, my name is Ann Utley. I am a member of the Board of the National Mental Health Association (NMHA) and Vice President for Communication and Education for the Texas Mental Health Association.

The National Mental Health Association is a private, voluntary organization providing leadership to confront the entire range of mental health issues at the local, state and national levels. In addition to the NMHA, I am testifying today on behalf of the Mental Health Law Project, National Alliance for the Mentally Ill, National Association of State Mental Health Program Directors and the National Council of Community Mental Health Centers.

Today I will discuss the need for improved Medicare coverage of mental health services, in the context of S 1127, Catastrophic Illness Coverage legislation. I will be addressing both the need to improve the basic mental health Medicare benefit and issues specific to S 1127 and HR 2470, the comparable House bill.

Discussing improved mental health coverage under Medicare in the context of catastrophic insurance certainly makes eminent sense to consumers, for whom a major mental illness very quickly becomes a financial catastrophe. For anyone with a serious mental illness, Medicare provides such limited reimbursement for essential services that one quickly finds oneself faced with substantial out-of-pocket expenditures.

While we recognize the concern that has been raised about financing basic Medicare benefits, such as improved mental health coverage, through the premium increase authorized under S 1127, and we recognize that it would be preferable to pay for this improved coverage through the normal financing mechanism of Medicare, we nonetheless recommend that these changes be made through S 1127. The principle that basic Medicare changes should not be made on S 1127 has

already been breached in both the House and Senate versions of the catastrophic insurance bill since other changes to basic Medicare coverage, such as home health care and prescription drugs are also being dealt with in the context of S 1127 and HR 2470. As long as this is the case, all changes to basic Medicare policies should be made in the same bill. We would object strenuously to an approach which separated out Medicare mental health improvements for later action (possibly) on Budget Reconciliation. In our experience, deferred too often means deleted when applied to legislation expanding mental health services.

Our highest priority is for improvement in outpatient mental health benefits. We applaud efforts by members of this Committee to address this need. S 1209, introduced by Senator Durenberger expands coverage for both routine physician visits and for psychotherapy and S 718, introduced by Senator Matsunaga increases the outpatient limit on mental health services. The House is also acting on legislation to improve the outpatient mental health limit (Ways and Means Committee bill) and to expand coverage of routine physician visits and increase the psychotherapy benefit (Energy and Commerce version of the bill). Unfortunately, despite these changes, Medicare will still include inappropriate incentives for inpatient care, even when that may not be the best locus of care in a given case, and certainly not the least costly. We will therefore suggest changes to Part A to encourage the use of partial hospitalization programs, as well as adjustments to the inpatient benefit under S 1127.

There is no need to explain to members of this subcommittee that the statutory limits on Medicare reimbursement and coverage discriminate against people with mental illness. You are well aware of the $250 limit on outpatient treatment of "mental, psychoneurotic and personality disorders" and the

lifetime limit of 190 days of care in a psychiatric hospital. These limits violate concepts of equity by treating serious mental illness as less significant or important than physical ailments. In addition, as with most discrimination, it is costly and shortsighted. My testimony urges you to take the initiative to end or, at a minimum, ameliorate the discrimination in coverage and reimbursement.

Medicare mental health policy encourages institutional care, discourages early intervention, and fails to cover the types of services which research shows are most effective at keeping individuals out of hospitals and functioning at their optimum level. In part, this deficiency is an accident of history, in that when Medicare was first enacted over 20 years ago, our attitude about mental illness treatment was significantly different. But while we have made enormous strides in the treatment of mental illness over the past two decades, Medicare mental health benefits have never been revised.

The current interest in catastrophic insurance allows us to re-examine mental health benefits under Medicare from the perspective of the elderly and disabled people who are spending considerable resources on health care.

It is extremely heartening to the MHA and to the other organizations which I represent today to see a unanimity developing in Congress that mental health benefits under Medicare are an issue which must be addressed. We have worked many years for this day. For too long, those suffering from a mental disorder have found the services which they need to cope with or recover from their illness denied them on the basis of misconceived and outdated limits on services which bear no relationship to good mental health treatment practices.

Prevalence of Mental Illness Among Elderly and Disabled

Before discussing in more detail the inadequacies of Medicare coverage and recommendations for improvement, let me first give you some statistics about the prevalence of mental illness in the Medicare population:

* Fifteen to twenty-five percent of elderly persons experience significant mental health problems;

* Nearly one out of four of all reported suicides are by persons 60 years or older. The death rate from suicide among the elderly is 1-1/2 times the rate for all ages;

* The likelihood of psychosis increases significantly after age 65 -- even more so beyond 75 -- and is more than twice as common in the over-75 age group as in the 25-34 year olds.

* Among the three million disabled people on the Social Security Disability rolls, who also receive Medicare benefits, an estimated 11% are mentally ill -- 300,000 people. And if you are familiar with the standards for determining mental impairment used by SSA, you know these 300,000 souls are severely and permanently disabled to the point that any gainful employment is impossible. Certainly without adequate and appropriate mental health services, the mentally ill on the DI rolls will remain there, continuing to draw disability payments and unable to return to productive employment.

Medicare Coverage for Mental Health Services

Despite the obvious need for mental health services for elderly and disabled people, Medicare discriminates against people with mental illness, not through administrative or arbitrary regulatory policy drawn up in the vast HHS bureaucracy, but through the language written into the law.

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Nearly 10 years ago, in its report to the President's Commission on Mental Health, the Task Panel on Mental Health of the Elderly concluded: "Existing policies in Medicare specifically, have tended to foster inpatient psychiatric treatment without adequate support for outpatient, day care, or ongoing rehabilitative services....Current limitations....have proven to be shortsighted, inequitable and costly. patient health and mental health services are often used when outpatient mental health care would be more appropriate and less expensive....The availability of ambulatory or day care based mental health services has the potential for reversing developing disabilities and keeping them from becoming permanent. Yet unless there is an adequate source of funding for these services, their potential will remain unfulfilled. (Department of Health, Education and Welfare, Mental Health and the Elderly: Recommendations for Action, the Report of the President's Commission on Mental Health: Task Panel on the Elderly and The Secretary's Committee on Mental Health and Illness of the Elderly. DHEW Publication #80-20960)

These conclusions are as apt today as in 1978. In addition, there are other policies and practices which discourage appropriate treatment.

* Hospital-based partial hospitalization services (day treatment or overnight care) are covered, but the same services when furnished through a provider other than a hospital are not reimbursable.
* Services of a rehabilitative nature are not covered at all, despite their proven effectiveness in maintaining seriously mentally ill individuals in the community and avoiding expensive hospital care.
* Outpatient prescription drugs are not covered, which causes major problems for seriously mentally ill people who must have expensive psychotropic drugs to combat the active symptoms of their illnesses.

Medicare policy does, however, permit some flexibility within these limits. For example, a recent change in Health Care Financing Administration policy allows physicians to bill for medical services to patients with Alzheimer's disease without regard to the limit on mental health care, although psychotherapy for such patients is still subject to the $250 limit. As research evidence gathers on the biological base of mental illnesses (such as the recent identification of the gene associated with manic-depressive illness), the arguments for further expansions of mental health treatment similar to this Alzheimer's coverage are strengthened.

Furthermore, patients using organized community settings, such as community mental health centers, have benefited from the "incident to" rule, which authorizes services (without regard to the outpatient reimbursement limit) of nurses and other health professionals when furnished incident to services of a physician. Under this rule, current Medicare policy allows reimbursement of psychologists, psychiatric nurses and social workers when provided incident to a physician's services. Community mental health centers and other organized care settings have used this rule to provide essential treatment to elderly and disabled clients, although the physician service remains subject to the Part B limit.

However, these policies, while they permit coverage of certain mental health services, do not begin to compensate for the basic thrust of the program, which is to cover inpatient general hospital care, and marginal, traditional and limited outpatient psychotherapy.

Consequences of Medicare's Inadequate Mental Health Coverage

Because Medicare fails to provide adequately for the needs of elderly and disabled Americans with mental illnesses, the public has to pay in other ways.

Elderly people, for example, occupy 30 percent of all public mental hospital beds and conservative estimates place the percentage of nursing home residents with a primary or secondary diagnosis of mental illness (including dementia) at 70 percent. Many of these individuals are inappropriately placed in these institutional settings.

The State of Minnesota recently estimated that a majority (89 percent) of its elderly citizens with a diagnosis of mental illness are living in nursing homes. The state further estimated that approximately 30 percent of these people could have avoided nursing home care if sufficient community support were available. Another 10-20 percent of those already in nursing homes might be suitable for community placement with extended services. Presuming that Minnesota is not atypical, revised Medicare policy which encourages early intervention and appropriate community services could reduce institutional costs, particularly under Medicaid, while greatly enhancing the quality of life for those now institutionalized.

Lack of money and inadequate Medicare coverage also leads people to forego needed care. For example, there are estimates that 25 percent of those elderly persons determined to be "senile" actually have treatable, reversible mental health conditions. The elderly poor without other insurance also average only 4.2 physician visits and 8.7 prescription drugs a year compared to 6.5 physician visits and 12.2 prescription drugs for the elderly who have Medi-gap insurance. Much is made of the fact that Medicare covers only 45 percent of the elderly's average health care bill. For mental health care services, this percentage is significantly lower.

Many patients in need of outpatient mental health services inappropriately use other Medicare benefits, thus costing the system unknown amounts in other expenditures. Psychiatric and mental health interventions have been shown to reduce the use of other medical and surgical services. By ignoring and failing to treat the patient's mental health needs, we do not eliminate those needs; they merely show up in other ways as patients report physical symptoms resulting from undiagnosed mental stress. There have been numerous studies of the cost-offsets achieved by providing mental health services, most notably:

- A quantitative review was made by Mumford et al. of 34 controlled studies of the effects of psychological interventions on recovery of persons who had recently suffered a heart attack or were facing surgery. The data showed these interventions producing large effects in terms of speeding recovery, decreasing requirements for analgesic and sleeping medication, and shortening hospital stays.
- A study of Blue Cross-Blue Shield federal employees program found that after a diagnosis of a chronic medical disease, those patients who began psychotherapy used 56 percent less medical services than a group with the same disease who didn't receive therapy. The savings are usually in hospital costs: preventing hospital admissions or shortening stays.
- A review of the effect of psychotherapy on utilization of other medical care showed the average effect to be a reduction in utilization of 20 percent.
- A study of psychiatric intervention in the postoperative course of elderly female patients requiring surgery for fractured hips showed that psychiatric consultation and liaison services led to a dollar benefit of almost $200,000 over the cost of the psychiatrist in one year.

* A series of cost-effective studies begun in the 1950s in West Germany was critical in persuading the national health insurance system in that country to include a 250-visit outpatient mental health benefit with a system of prospective approval and peer review.

Recommendations:

We would like to recommend placing mental health services in Medicare on the same basis as all other benefits. However, we recognize that a proposal like that would not be seriously considered in this fiscal climate. Therefore, we recommend expanded but still limited outpatient benefits which represent a realistic response to the needs of Medicare beneficiaries who are mentally ill.

Outpatient Benefits

As stated earlier, our highest priority is for improvements to the outpatient mental health benefit. We urge a package of outpatient reforms which has been endorsed by all of the organizations for which I am testifying today and also by the American Psychiatric Association and American Psychological Assocation. Specifically:

* Routine physician visits for purposes of monitoring the patient's condition, particularly the monitoring of medications and their side effects but specifically excluding psychotherapy, be covered on the same basis as any other physician visit for any other illness, and

* Psychotherapy be a covered services for up to 25 visits per year.

These changes have already been included in the Energy and Commerce Committee version of the House catastrophic insurance bill, HR 2470.

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The coverage of routine physician visits, sometimes termed medical management, removes a highly discriminatory restriction from the law--one that could also be potentially dangerous for patients on psychotropic medications, many of which have very serious side effects. Currently, visits to physicians for medication monitoring fall within the $250 cap. Removing the cap from these visits would allow physicians to closely monitor potentially toxic medications as closely as good medical practice dictates, without arbitrary limits which have no medical basis.

The other change that we urge would alter the limit on outpatient psychotherapy from a dollar limit (currently $250, under S 1209, $1,215 and under S 718 and HR 2470 $1,000) to a visit limit of 25 visits per year. According to CBO, 25 visits is an equivalent benefit to the $1,000 cap. The advantage of this change for patients is two-fold. First, and most importantly, it protects beneficiaries against inflation. It is now more than 20 years since the original $250 limit on psychiatric care was enacted, and no adjustment has been made in that limit for the entire 20 years. The rate of inflation during that period of time, means that the original $250 now has the purchasing power of only $57! Indeed, raising the limit to $1,000 (or 25 visits) still leaves beneficiaries a little short of a benefit which is equivalent to the original coverage. A shift to a limit on visits avoids this problem in the future, and it is an approach increasingly being adopted by states as they regulate health insurance coverage for mental illnesses. A second advantage of shifting to a visit limit is that patients can more easily keep track of the benefit and how much of it has been "spent" and how much more remains available to them.

Part A Coverage

In addition to the changes to outpatient benefits described above, the organizations I am testifying for today also urge the following policy regarding Part A services:

* That the unlimited coverge of psychiatric services in a general hospital, which is now included in S 1127, be changed to a 75-day-a-year limit for psychiatric services in both general hospitals and in psychiatric hospitals, thus eliminating the current 190 day lifetime limit on psychiatric hospital services.

* Coverage beyond the 75 day limit should be provided if found necessary through medical necessity reviews, in a manner similar to the current CHAMPUS program.

* Reimbursement for inpatient services should be made only for patients receiving active treatment.

* A new benefit of partial hospitalization services, when furnished through a hospital, community mental health center or other qualified provider, should be added, with a trade-off of three days of partial hospitalization services for each day of inpatient care under the above annual limit.

These proposed changes to the Part A inpatient section would eliminate the current 190-day limit on care in a psychiatric hospital and establish instead a reasonable inpatient limit on psychiatric services in all settings. Such a limit further allows for a trade-off mechanism between 24-hour-a-day inpatient stays and partial hospitalization services. Finally, the inpatient limit we propose should provide savings to the Medicare program.

The major benefit for patients from these changes, however, would be the coverage of partial hospitalization services, which are frequently a very effective alternative to inpatient care. Partial hospitalization programs provide day services for patients who continue to live in the community, or evening and night services for patients who are able to leave the hospital during the day. The costs of partial hospitalization, according to data compiled by the National Institute of Mental Health are generally about one third as expensive as a 24-hour-a-day inpatient stay. For example, at the Psychiatric Institute here in Washington D.C., partial hospitalization services cost $215 for an intensive day program and $149 for an intermediate program, compared to inpatient rates of $579-$722. Under the CHAMPUS program, partial hospitalization costs $58 a full day ($40 for night care) compared with $264 for an inpatient day.

Coverage of Prescription Drugs

Medications for mental illnesses should be covered to the same extent that they are covered for any other illness. We strongly support a change to S 1127 to include coverage of medications for all Medicare beneficiaries under a catastrophic plan.

Limitations on Catastrophic Costs

Finally we would like to address an issue which is raised in the House bill, whereby only the patient's first $250 in out-of-pocket costs for covered mental health services would count towards the catastrophic trigger. We find this provision highly discriminatory. Clearly, copayments for covered mental health services drain an individual's resources just as much as equivalent copayments for other Medicare services. We can see no reason to make this

distinction, and urge this committee not to adopt such a policy as improvements are made in Medicare mental health benefits.

Mr. Chairman, as your subcommittee studies ways to address the costs of catastrophic illness, we urge you to moderate the discrimination in current law. Medicare's restrictions prevent both elderly individuals with acute problems, and elderly and disabled people with chronic mental illnesses from receiving the range of services they need in the most appropriate settings. The result is unnecessary, costly and restrictive forms of inpatient hospital or nursing home care.

We ask you to consider our recommendations for enhancing outpatient day treatment and inpatient coverage for mentally ill Medicare beneficiaries. We believe they are reasonable and realistic. They do not entirely eliminate the historic and untenable inequity in the law. But they do establish a workable set of benefits that represent a significant improvement over existing law without adding substantial cost to the bill. Your Committee has the opportunity to design legislation that truly will improve the lives of millions of Medicare beneficiaries who are mentally ill.

Thank you Mr. Chairman..

STATEMENT OF MALCOLM STRICKLER, ADMINISTRATOR, FRIENDS HOSPITAL, PHILADELPHIA, PA, ON BEHALF OF THE NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

Mr. STRICKLER. Mr. Chairman, I am Malcolm Strickler, Administrator of the country's oldest private psychiatric hospital, Friends Hospital, in which more than 40 percent of our patient population is Medicare.

As President of the National Association of Private Psychiatric Hospitals, I want to thank you for this opportunity to testify before the Senate Finance Committee's Health Subcommittee on the need to improve both inpatient and outpatient psychiatric benefits under Medicare.

Our written statements reviews the various Medicare outpatient psychiatric proposals being considered by this committee and the House. NAPPH strongly supports the need to expand the outpatient benefit which has not been improved since the beginning of Medicare in 1965.

We make the following recommendations regarding the outpatient psychiatric benefit under Medicare:

First, establish 25 visits annually for psychotherapy services;

Second, exempt medical management for mental disorders from the 25 visit limit and reimburse these services in the same manner as all other physician care; and,

Third, all deductibles and copayments incurred with respect to a covered mental illness should be counted toward the limit for out-of-pocket costs in the committee's catastrophic bill.

Mr. Chairman, most of the discussion up to this point has focused on outpatient care under Medicare. Although it is clear that the present outpatient psychiatric benefit is woefully inadequate in today's world and must be improved, it is our contention that the full continuum of services from inpatient to partial hospitalization to outpatient care must be a part of the committee's legislative package if we wish to assure that Medicare beneficiaries receive the appropriate level of care in the least costly setting. The current inpatient and outpatient psychiatric benefit creates incentives to treat people based on reimbursement policies rather than on what is clinically most appropriate. And this leads to severe distortions in the cost per beneficiary.

Under the Medicare program at this time, inpatient psychiatric care in a specialty psychiatric hospital is limited to 190 days during the Medicare beneficiary's lifetime, while psychiatric care provided in a general hospital has the limits that apply to inpatient care for other illnesses. The 190-day lifetime limit was enacted when State hospitals was the primary setting for psychiatric care, and many patients stayed for long periods of time. Now there are literally hundreds of private psychiatric hospitals, partial hospitalization programs, and other treatment options that specialize in the active treatment of serious mental illness.

Today, all of psychiatry and private psychiatric hospitals in particular, is using more aggressive and effective forms of treatment than were available when Medicare was created. The 190-day life-

time limit has become an outmoded and unnecessary restriction to highly effective psychiatric hospital care.

One of the strongest arguments in favor of repealing the 190-day lifetime limit is that very few of Medicare's 31 million beneficiaries have actually exhausted their lifetime limits. However, those persons who have reached this arbitrary limit are the most seriously ill and have a truly catastrophic illness.

The limit denies these truly needed beneficiaries access to critical services to which during acute episodes they are entitled under the philosophy of the Medicare program.

NAPPH's long-standing policy has been to eliminate the 190-day lifetime limit. We believe that the repeal of this limit is long overdue. There are presently in place controls to assure that overutilization of inpatient psychiatric hospital care will not occur. And we discuss those controls in detail in our written statement. However, we do recognize that there may be some concern that these controls are not sufficient. Therefore, NAPPH would recommend, one, a 90-day annual limit with medical review for continued care to be applied to inpatient psychiatric treatment instead of the 190-day lifetime; and, two, the establishment of a partial hospitalization benefit under Part A with a tradeoff of two partial hospitalization days for one inpatient day taken off the annual limit.

The second recommendation will provide a level of care for those who do not need the intensive environment of the inpatient setting at significantly lower cost to all of us taxpayers.

Mr. Chairman, thank you again for giving us this opportunity to present our views on psychiatric care under Medicare. We look forward to working with you and the committee as you move forward on this most important matter. I would be pleased to answer questions.

Senator MITCHELL. Thank you, Mr. Strickler.

Mr. Spielman.

[The prepared written statement of Mr. Strickler follows:]

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The National Association of Private Psychiatric Hospitals

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STATEMENT

of the

NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

on

MEDICARE COVERAGE OF PSYCHIATRIC CARE

Presented by

MALCOLM D. STRICKLER

Administrator, Friends Hospital

Philadelphia, Pennsylvania

President,

National Association of Private Psychiatric Hospitals

Before the

SENATE FINANCE COMMITTEE

JUNE 18, 1987

Mr. Chairman and members of the committee, my name is Malcolm D. Strickler and I am the Administrator of Friends Hospital in Philadelphia, Pennsylvania -- a non-profit private psychiatric hospital. I am also the President of the National Association of Private Psychiatric Hospitals, which represents over 250 nongovernmental, private psychiatric hospitals nationwide. On behalf of NAPPH I want to thank you for this opportunity to testify before the Senate Finance Committee on the need to improve the inpatient and outpatient psychiatric benefit under Medicare. Mr. Chairman, on March 19, NAPPH, the American Psychiatric Association, and the National Alliance for the Mentally Ill presented testimony before this committee on the need for mental health care services under Medicare. I will not review that information again today, but would refer you to the March 19 testimony.

Mr. Chairman, I appear before you today encouraged that after 22 years of discriminatory coverage of psychiatric services under Medicare we are on the brink of redressing some of the inadequacies in the mental illness benefit. As you know, the House Ways and Means' Committee has proposed raising the outpatient psychiatric benefit from the original 1965 $250 level to $1000 annually as part of their catastrophic health insurance legislation. Moreover, just last week, the House Energy and Commerce's Health and Environment Subcommittee reported out its version of catastrophic health care, which would allow 25 outpatient psychiatric visits annually instead of the $1000 annual limit included in the Ways and Means' package.

In addition, the bill would exempt medical management of mental disorders from the annual visit limit and would subject these services to the same copayments as other physician care. These positive steps in dealing with the Medicare psychiatric benefit do not stop in the House. Several distinguished members of this committee, including you, Mr. Chairman, Senator Matsunaga, and Senator Durenberger have all developed proposals to improve mental health coverage under Medicare. I salute your concern and understanding of the mental health needs of all Americans. I would now like to summarize each of these proposals and then make our recommendations.

Senator Matsunaga's Bill (S.718)

Senator Matsunaga's bill would provide coverage for outpatient psychiatric care on the same basis as other physical illnesses under the Medicare program. Currently Medicare only allows $500 in charges for outpatient psychiatric services and reimburses 50% of that amount, that is, $250 annually. We strongly support an end to discrimination between mental illness and physical illness coverage for both outpatient and inpatient care. This legislation, S.718, addresses the outpatient portion of the psychiatric benefit.

Senator Durenberger's Bill (S.1209)

Senator Durenberger's bill would establish a varied copayment

system based on the number of visits a Medicare beneficiary receives for psychotherapy services. Visits 1-5 would have a 20% copayment, visits 6-20 would have a 50% copayment, and visits 21-30 would have an 80% copayment. The benefit would be capped at 30 visits or $2700 in charges annually. In addition, the bill would exempt medical management of mental disorders from the 30 visit cap and would subject these services to the same copayments as all other physician care. Medical management of mental and addictive disorders includes the monitoring of medication, assessment of current functioning and progression of symptoms, ordering of laboratory tests and reviewing these tests, and mental status evaluation.

NAPPH strongly supports the two main components of this legislation. First, the establishment of an annual visit limit instead of a dollar limit is important because over a period of time inflation will erode the value of a dollar limit, but this would not be true for a visit limit. Also, a visit limit would be more easily understood by medicare beneficiaries than a dollar limit. Second, the exemption of medical management would be important because these services are no different than the services provided by other medical professionals, and therefore should be paid in the same manner as all other physician services.

The one concern that we do have with S.1209 is the varied copayment structure. First, we believe that this type of copayment structure would be administratively complex and confusing to the beneficiary.

Second, although we support the notion that individuals should be encouraged to obtain care at the earliest stages of the illness, the legislation would penalize those persons who are the most seriously ill and need the full 30 or more visits.

Senator Mitchel's Proposal

It is our understanding that Senator Mitchel's proposal would base reimbursement on types of psychiatric diagnoses. It is our view that this type of approach would be administratively complex and confusing to the Medicare beneficiaries. We would agree, of course, that Medicare should only pay for medically necessary services; however, payment by diagnosis may arbitrarily exclude certain medically necessary services. In addition, this type of payment system would provide incentives to use those diagnoses that would be reimbursable under the catastrophic benefit.

NAPPH Recommendation for Outpatient Psychiatric Care

After reviewing the various outpatient proposals that are currently being considered by this committee and the House, and taking into consideration the financial constraints that we must operate within, NAPPH would make the following recommendations:

1) Establish 25 visits annually for psychotherapy services;
2) Exempt medical management for mental disorders from the 25

visit limit and reimburse these services in the same manner as all other physician care;

3) All deductibles and copayments incurred with respect to a covered mental illness should be counted towards the limit for out-of-pocket costs in the committee's catastrophic bill.

Mr. Chairman, most of the discussion up to this point has focused on outpatient care under Medicare. Although it is clear that the present outpatient psychiatric benefit is woefully inadequate and needs desperately to be improved, it is our contention that the full continuum of services from inpatient to partial hospitalization to outpatient care must be part of the legislative package in order to assure that Medicare beneficiaries receive the appropriate level of care in the least costly setting. The current inpatient and outpatient psychiatric benefit creates incentives to treat people based on reimbursement policies rather than on what is clinically most appropriate.

At the end of our statement we have included a table detailing Medicare inpatient expenditures and discharges by types of inpatient psychiatric settings. In addition, I would request that an NAPPH publication entitled "Using Inpatient Psychiatric Benefits Wisely," which explains the different levels of care provided in the various inpatient psychiatric settings, be included in the hearing record.

Medicare's Discriminatory 190-Day Lifetime Limit

Mr. Chairman, there is an additional issue I would like to highlight for your consideration, which deals with the Medicare 190-day lifetime limit for psychiatric hospital care. Under the Medicare program at this time, inpatient psychiatric care in a specialty psychiatric hospital is limited to 190-days during a Medicare beneficiary's lifetime, while psychiatric care provided in a general hospital has the same limits as inpatient care for other illnesses. The 190-day lifetime limit was enacted when state hospitals were the primary setting for psychiatric care and many patients stayed for long periods of time. Now there are hundreds of private psychiatric hospitals, partial hospitalization programs, and other treatment options that specialize in the active treatment of severe mental illness. Today, all of psychiatry -- and private psychiatric hospitals in particular -- are using more aggressive and effective forms of treatment. The 190-day lifetime limit has become an outmoded and unnecessary restriction to the highly effective psychiatric hospital care.

NAPPH's long-standing policy has been to eliminate the 190-day lifetime limit. We believe that the repeal of this limit is long overdue. There are presently in place controls to assure that over-utilization of inpatient psychiatric hospital care will not occur. First, private psychiatric hospitals are presently paid by Medicare on a per case limit (TEFRA) basis, which creates strong

incentives to keep length of stays as short as appropriately possible. According to NAPPH data, the average length of stay for Medicare patients in our member hospitals in 1986 was 21.1 days, down from 23.5 days reported by HCFA for FY84. Second, there are presently utilization controls through Professional Review Organizations and other mechanisms. Third, each of the NAPPH hospitals has admission criteria, immediate psychiatric assessment on admission, and internal quality assurance programs. The lack of a limit on psychiatric care provided in a general hospital creates incentives to admit patients to this setting even though it may not be the most appropriate for a patient's specific needs.

One of the strongest arguments in favor of repealing the 190-day lifetime limit is that very few of Medicare's 30 million beneficiaries have actually exhausted their lifetime limits. However, those persons who <u>have</u> reached this arbitrary limit are the most seriously ill and have a truly catastrophic illness. The limit denies these truly needy beneficiaries access to critical services. As of December, 1985, there were 10,413 Medicare beneficiaries who have exhausted their 190-day lifetime limit. Each year it is estimated that an additional 1,000 beneficiaries will reach the 190-day limit. Again, although these numbers may seem small, it is important to point out that many of these persons are <u>young</u> Americans who are eligible for Medicare through the Social Security Disability Insurance Program (SSDI). Many of these persons suffer from serious mental illness, and it is <u>these most vulnerable</u>

Medicare beneficiaries, who will need care periodically throughout their entire lives, that are most hurt by the 190-day lifetime limit.

NAPPH Recommendations for Inpatient Psychiatric Care

While we submit that there are adequate controls to avoid unnecessary hospitalization, we do recognize that there may be some concern that these controls are not sufficient. Therefore, NAPPH would recommend:

(1) a 90-day annual limit with medical review for continued care to be applied to inpatient psychiatric treatment instead of the 190-day lifetime limit.

(2) the establishment of a partial hospitalization benefit under Part A with a "trade-off" of two partial hospitalization days for one inpatient day off the annual limit.

The combination of an annual limit and the partial hospitalization benefit would provide Medicare beneficiaries who suffer from mental illness with a continuum of services that could be tailored to their specific needs. Patients would no longer receive care based on who gets paid, but rather on what care is the most clinically appropriate depending on the severity of illness and extent of impairment.

For the mentally ill, a lifetime is much too long to have waited for an adequate psychiatric benefit. Therefore, we would urge

the committee to seize this opportunity and make some meaningful improvements to both the inpatient and outpatient psychiatric benefit under the medicare program.

Mr. Chairman, thank you again for giving us this opportunity to present our views on psychiatric care under Medicare. We look forward to working with you and the committee as you move forward on this most important matter.

DISTRIBUTION OF HOSPITALS, DISCHARGES, AND CHARGES BY TYPE OF HOSPITAL
(FY84 Medicare - PatBills) [Reprinted]

	Number of Hospitals	Number of Discharges			Billed charges (in millions)	
		Avg. per hospital	Number	Percent	Dollars	Percent
Total, all hospitals	6,281	55	345,898	100.0	$1,593.5	100.0
Psychiatric hospitals	435	148	64,368	18.6	434.5	27.3
Public	208	159	33,106	9.6	192.8	12.1
Proprietary (Private)	227	138	31,262	9.0	241.7	15.2
Not for Profit	84	148	12,459	3.6	102.4	6.4
For Profit	143	131	18,803	5.4	139.3	8.7
General Hospitals	5,846	48	281,530	81.4	1,159.0	72.7
Exempt unit 84	635	173	109,685	31.7	534.3	33.5
Exempt unit 85	206	133	27,451	7.9	163.5	10.3
NonExempt unit	431	111	47,896	13.8	183.0	11.5
No unit (scattered beds)	4,574	21	96,498	27.9	278.2	17.5

Using Inpatient Psychiatric Benefits Wisely

The National Association of Private Psychiatric Hospitals
1319 F Street, N.W.
Washington, DC 20004
202-393-6700

Mental Illness and the Current Inpatient Delivery System

Introduction

Very few people will ever need to be hospitalized for mental illness. Most of the nearly 30 million Americans suffering with this illness can find help for acute problems with less intensive interventions than inpatient care.

But if and when someone does need hospitalization because of the severity of their illness, it's important to understand the options available in the inpatient field. In fact, most people—including the insurers who provide benefits and the patients who require treatment—are unaware of the very real differences among inpatient settings and are often confused about how to select the most appropriate one within the continuum of available services.

The National Association of Private Psychiatric Hospitals (NAPPH) has developed this overview to identify the range and scope of care of various inpatient providers, their economic benefits, and the different levels of severity of illness each is equipped to handle.

Beyond that, we hope to provide a basis for more effective and efficient use of private psychiatric hospitals as a central part of the continuum of care.

An Overview of Mental Illness

Mental illness is one of the few remaining taboo subjects in our society. No one wants to believe that mental illness can touch them or their families. But statistics from the National Institute of Mental Health show that 19 percent of Americans over the age of 18 (or 29.4 million adults) suffer with this disease.

Emotional and developmental disorders arise in about 12 million children under the age of 18, according to the American Psychiatric Association. These disorders can seriously impair a youngster's emotional and intellectual development and, left untreated, may lead to chronic lifelong mental illness.

Even with these staggering numbers, fewer than one-fifth of the nearly 30 million people who struggle with mental illness seek mental health services. Many attribute this to a lack of understanding about their illness, fear of social stigma, and confusion about what treatment is available and how to obtain it. These figures are especialiy disturbing when compared to the way people deal with a physical illness.

The fact is mental illness is treatable. And treatment is available.

A Spectrum of Treatment Settings

There are a number of different settings in which patients receive psychiatric care, ranging from mental health professionals' offices to any of a number of types of hospitals. Where a patient will receive services depends on a number of factors. Ideally, the best treatment setting for a patient matches the severity of illness with the individual patient's needs. For example, patients who are in so much emotional pain that they can't function at work or at home may require acute hospitalization for a short time to provide a safe, controlled environment in which they can be evaluated and treated. Some patients will do best in private psychiatric hospitals where special considerations can be made for age-specific needs (for example, school for adolescents) and where highly trained and skilled treatment teams are involved in treatment which is individualized for each patient.

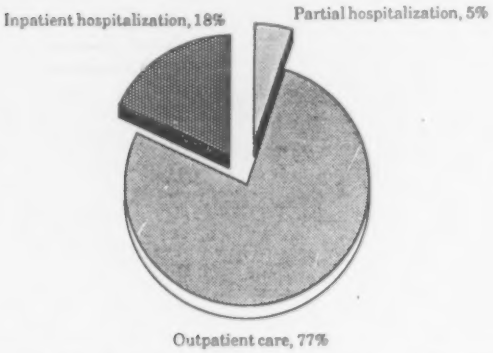
Different types of inpatient settings offer different services in order to meet the needs of the patients that facility serves best.

It is in the private psychiatric hospital setting that the full array of services within the continuum of care is available to help transition the patient out of the hospital or prevent hospitalization altogether.

By far, the largest number of people are treated as outpatients.

Illustration 1: Treatment Settings Available Based on Level of Impairment

Illustration 2: Percent Psychiatric Patients in Three Settings



Of over 5 million patients treated for psychiatric illness, 18% were ill enough to require hospitalization.

Far fewer require the intensity of other levels of care. For example, a 1986 study by the federal government's Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) showed that of 5.6 million episodes of care, 18 percent were ill enough to require inpatient hospitalization or residential treatment. The vast majority were able to use far less intensive levels of care. For example, 77 percent used outpatient care and 5 percent used partial hospital care.[1]

Each of these settings plays an important role in the continuum of mental health care. But for those people whose illness is seriously debilitating and often life-threatening, the availability of specialty hospitalization is mandatory.

Inpatient hospitalization may occur in a variety of treatment settings, from general hospital beds to specialty psychiatric hospitals. The role of each of these inpatient settings will be detailed later in this report. In any of these settings, the criteria for inpatient treatment is not related to diagnosis. A particular psychiatric diagnosis does not consistently predict either the prognosis, the outcome, or the intensity of services needed.[2] Instead it is **the degree of impairment** or **the severity of illness** that will determine the need for hospitalization. So too the length of hospital stay is not related to diagnosis, but to the degree of impairment and amount of time required to reduce the impairment.

Specialty hospital inpatient treatment is used only when specific criteria are met. For example, hospitalization would be recommended when people are so seriously disturbed that they threaten to harm themselves, when their emotional problems prevent them from carrying out basic daily requirements such as performing at their job or carrying out duties at home, when they cannot be treated at a lower level of care, or when they fail to respond after repeated attempts to use less intensive levels of care.

Because they serve a seriously disabled population, inpatient settings tackle a wide variety of problems. Within the inpatient sector, a range of health care settings have developed, each filling a unique role. It is the differences among these settings (including whether there is expectation for a patient's improvement, different levels of severity of illness, different environments and types of treatment modalities) that will be focused on throughout the remainder of this paper.

The Inpatient Psychiatric Delivery System

The differences among kinds of inpatient psychiatric hospitals is much greater than that seen in most of the general medical and surgical system. This degree of variance can be attributed primarily to the very diverse needs of the mentally ill. Speciality psychiatric hospitals serve a unique clientele and play a role which cannot be simply transferred to outpatient clinics or general hospital settings.[3]

The inpatient psychiatric delivery system covers a wide spectrum of public and private facilities.

NAPPH Specialty Hospitals

In the United States there are approximately 250 psychiatric specialty hospitals which have met the rigorous definition and criteria of the National Association of Private Psychiatric Hospitals (NAPPH) as to what constitutes a psychiatric specialty hospital.

To be eligible for membership,

these specialty hospitals must have fully trained psychiatrists in charge of patient care. The facility must provide active treatment to all patients—that is, treatment that can be expected to result in improvement in a patient's condition. All active member NAPPH hospitals are accredited by the Joint Commission on Accreditation of Hospitals (JCAH), the arbiter of hospital quality. In addition to requiring JCAH certification, NAPPH member hospitals are also surveyed by NAPPH clinical staff before their application is considered. NAPPH is the only hospital association that surveys its membership prior to granting full membership.

NAPPH hospitals, representing the overwhelming majority of eligible private psychiatric hospitals in the country, are also distinguished by meeting special requirements of the Federal government on staffing, treatment planning, treatment team concepts, and other requirements.

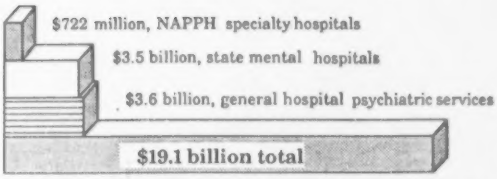
Other Inpatient Settings

In addition to specialty psychiatric hospitals, there are over 2,500 general hospital psychiatric units. This number includes nearly 900 organized units with psychiatric staff. There are over 1,500 unorganized units (or "wings") often staffed by general hospital personnel.

Another 4,500 general hospitals provide mental health care without any designated psychiatric beds, accepting patients into "scatter beds" staffed by general health care practitioners and nurses.

There are also 218 state and county facilities in the public sector.

Illustration 3: Direct Costs of Mental Health Care


$722 million, NAPPH specialty hospitals
$3.5 billion, state mental hospitals
$3.6 billion, general hospital psychiatric services
$19.1 billion total

Specialty psychiatric hospitals use only 3.7 percent of total mental health resources. Because patients are carefully screened, only those truly needing this intensity of services are treated. Specialty psychiatric hospitals provide a full range of highly specialized, medically supervised psychiatric programs.

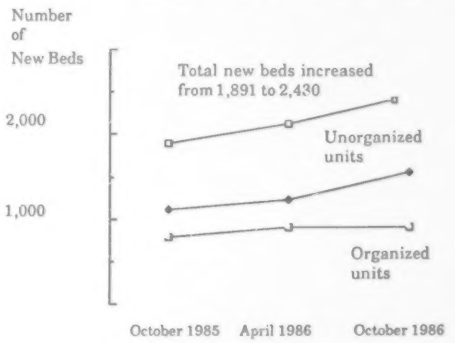
Trends and Concerns

One of the most significant changes in the delivery of psychiatric inpatient care has been an expansion of the role played by short-term general hospitals in the treatment of milder forms of psychiatric illness. This has been prompted by a lessening of stigma and more awareness of the value of early treatment.[4]

The number of psychiatric units in general hospitals has been increasing dramatically. There was, for example, a 26 percent increase in separate psychiatric units between April and October 1986, a continuation of a trend begun in 1983.

However, as indicated in a variety of studies, short-term general hospitals may not be

Illustration 4: Growth in Psychiatric Units in General Hospitals, 1985-1986



The number of psychiatric units in general hospitals has been increasing dramatically. There was, for example, a 26 percent increase in separate psychiatric units between April and October 1986, a continuation of a trend begun in 1983.

equipped, staffed or constructed to provide needed care and treatment for patients with moderate to severe psychiatric disorders.[5,12]

Another focal point of general hospital utilization is the hospitalization of patients with a secondary diagnosis of psychiatric illness. This would include those patients with a primary diganosis of a physical illness and a secondary diagnosis of a mental illness who are admitted to medical or surgical beds. Typically these patients receive treatment for psychiatric disorders from physicians who are not psychiatrists and other health personnel not trained in psychiatric care.

How—and whom—each setting serves will be examined more closely in the next section.

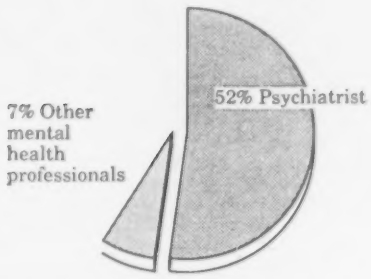
NAPPH Psychiatric Specialty Hospitals: Why We Are Unique

A freestanding psychiatric hospital specializes in the development of psychiatric programs for the evaluation and treatment of serious psychiatric disorders. Specialty psychiatric hospitals devote staffing and administrative resources into one medical specialty and provide exclusively psychiatric treatment.

We treat serious illness.

Patients admitted to NAPPH specialty hospitals are most often referred by psychiatrists and other mental health professionals. Most patients referred to NAPPH hospitals have had a history of psychiatric illness with extensive outpatient therapy and/or previous hospitalization. For example, specialty psychiatric hospital patients had an average of 24.8 days of care in other settings before being admitted to an NAPPH hospital, compared with patients seen in unorganized units of general hospitals who had an average of only 7.6 days of prior care. All patients referred to NAPPH hospitals must be evaluated by psychiatrists to determine the level of services needed. More than half of all referrals to private psychiatric hospitals are made by psychiatrists who have determined that less intensive levels of care are inappropriate.

Illustration 5: Inpatient Referral Source for NAPPH Specialty Hospitals



The majority of patients seen in private psychiatric hospitals have been referred by psychiatrists who have evaluated the need for an intensive level of service.

"NAPPH hospitals are distinguished by meeting special requirements of the Federal government on staffing, treatment planning, treatment team concepts, and other requirements."

Illustration 6: Distribution of Medicare Case Mix by Hospital Type

	NAPPH specialty hospital	Organized unit in general hospital	Unorganized unit and scatter beds in general hospital
Psychoses	60.6%	39.8%	27.9%
Depressive illness	11.8%	14.1%	13.3%
Substance and alcohol abuse	12.1%	15.2%	18.5%

Private psychiatric hospitals serve serverely ill patients. More than 60% of private psychiatric hospital Medicare patients, for example, are suffering from psychotic illness.

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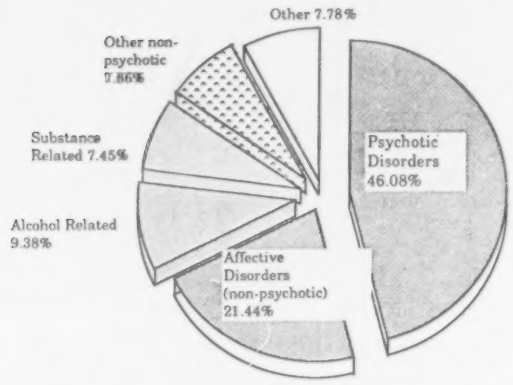
Illustration 7: Principal Discharge Diagnosis in NAPPH Specialty Hospitals



Private psychiatric hospitals serve severely ill patients. Of all patients seen by NAPPH hospitals, nearly half (46.08%) were treated for psychotic disorders.

Psychiatric specialty hospitals have a longer length of stay than the general hospital psychiatric services because of the illness of the patient population served.[6]

The patients seen in NAPPH psychiatric hospitals most often have complex illnesses involving multiple problems, which require the expertise of a full range of mental health specialists. For example, several studies found that one-third of the adolescents hospitalized for acute psychiatric disturbance in private psychiatric hospitals showed an early history and a progressive manifestation of learning disability. Learning disabilities were evident despite, in many cases, the educational and therapeutic supports these youngsters received during the early school years. In these studies, cases were distributed across a variety of diagnostic categories.[7]

We are intensively staffed to provide individualized services.

Because of the complex nature of patients' problems, NAPPH specialty hospitals need to be very labor-intensive, with a higher staff-to-patient ratio than any other inpatient psychiatric treatment setting. As reported by the American Hospital Association, psychiatric specialty hospitals have the highest labor intensity compared to all other medical, surgical, or rehabilitative treatment environments.

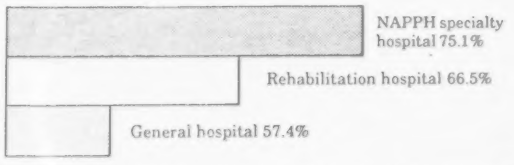
We have a range of treatment programs.

Treatment programs in NAPPH psychiatric specialty hospitals are generally grouped into five major categories: geriatric, adult, adolescent, child, and substance abuse. In addition, many hospitals have specialized programs to treat specific diagnostic categories.

Treatment programs are managed by specially qualified psychiatric treatment teams under the supervision of a psychiatrist. These teams are made up of psychologists, clinical social workers, rehabilitation counselors, certified alcoholism counselors (when appropriate), occupational and recreational therapists, psychiatric nurses, certified teachers (when appropriate), and trained mental health technicians.

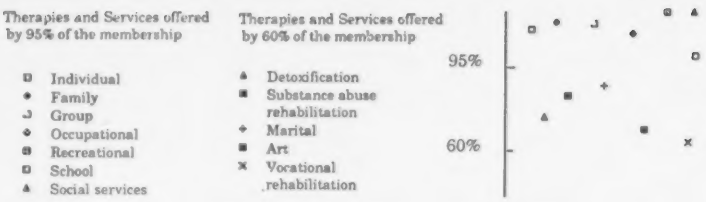
Treatment modalities in psychiatric specialty hospitals encompass the biological/

Illustration 8: Labor Intensity By Type of Hospital, 1982



Psychiatric specialty hospitals have the highest labor intensity compared to all other medical, surgical, or rehabilitative treament environments.

Illustration 9: Hospital Procedures provided by NAPPH Specialty Hospitals



psychological/social approach and often involve the family, employer, and significant others within the patient's support system. In other words, treatment looks at how physical health impacts on emotional well-being, and how both of these are impacted by how the patient interacts with others at work, at home, at school, or in society. An initial evaluation of each patient is followed by the development of a patient-specific plan of care, with definitive goals to be reached. Discharge planning is also developed as an integral component in the individual's treatment plan.

All NAPPH specialty programs provide intensive treatment with 24-hour-a-day clinical supervision by trained psychiatric professionals. Patients are involved for a minimum of between five and seven hours per day in **active** treatment, including time spent in treatment-directed therapeutic recreation and social activities (and, for adolescents, time in school programs that are an integral part of the treatment program). From this, the intensity of the treatment patients receive in private psychiatric hospitals becomes apparent.

We offer a continum of care.

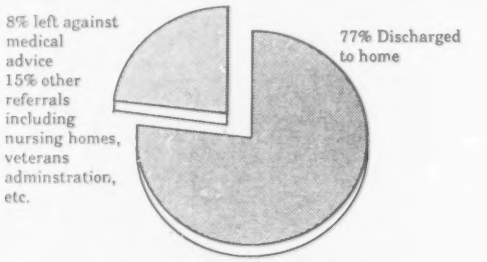
Additionally, NAPPH psychiatric specialty hospitals offer a continuum of services, which allows patients to move into less intensive levels of care as their treatment progresses. This presents a different type of treatment from the general hospital and public facilities, which may not offer more than one level of care.

In NAPPH psychiatric hospitals, the goal of treatment is to stabilize patients and return them to regular routines with as little disruption to their lives as possible. This philosophy is reflected in the high number of patients (77 percent) who are discharged to their homes. In contrast, many general hospital units must refer patients for more intensive care in private or public hospitals, or readmit them more frequently.

We have special therapeutic facilities.

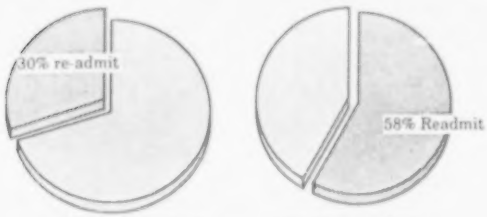
With a disease that shatters self-esteem and that still stigmatizes individuals, providing a hopeful and uplifting treatment setting is not a luxury. The environment is an important treatment element. In planning a facility, details like interior colors or artwork must be chosen for their impact on a troubled mind. Facilities must be built and furniture chosen with an eye for the safety of a potentially self-destructive or hyperactive patient. Additional safety features such as safety glass and appliances must be considered for patient protection.

Illustration 10: Percent of Patients Discharged to Home


8% left against medical advice
15% other referrals including nursing homes, veterans adminstration, etc.
77% Discharged to home

Most patients in private psychiatric hospitals are able to return home following hospitalization. In addition, private psychiatric hospitals provide a continuum of care for those who do need other levels of service.

Illustration 11: Readmission Rates for Chronic Alcoholics



70% Non-readmit
NAPPH Specialty Hospitals

42% Non-readmit
General Hospitals

This readmission rate for chronic alcoholics reflects readmissions for chronic alcoholism and other underlying psychiatric disorders. The data emphasizes the general clinical consensus that detoxification without therapy is not cost-effective.

Special accommodations that are age- or program-specific, such as classrooms or occupational therapy facilities, must be made. Spacious and comfortable rooms that will encourage patients to take pride and responsibility for their daily living are a necessity.

Overall, the environment in NAPPH psychiatric specialty hospitals closely replicates the home, community, and work environments. An individual treatment plan is developed by a team of psychiatric specialists to address the patient's individual needs. All the interventions used (including therapeutic recreation, social activities, and the therapeutic environment) are tailored to resolve the patient's individual problem and return that person to the community at his or her highest level of functioning.

We are economically efficient.

NAPPH psychiatric specialty hospital room and board rates are less expensive per patient day than psychiatric units of general hospitals. This is because psychiatric specialty hospitals do not require expensive, high-technology ancillary equipment, space, or medical/surgical personnel. They also cost less per square foot per bed and maintain lower administrative costs.[8]

We participate in a national referral network.

Within the psychiatric specialty hospital sector, there are a number of NAPPH hospitals that have developed into national referral centers. Typically, these hospitals provide treatment for patients who have had four to five previous hospitalization failures and require extremely intensive treatment often associated with fairly long lengths of stay. These long-term care specialty hospitals provide treatment to patients who are diagnosed as still having the potential for significant improvement. This type of hospital is labor intensive due to the difficulty of the disorders of the patient population.

"Overall, the environment in NAPPH psychiatric specialty hospitals closely replicates the home, community and work environments."

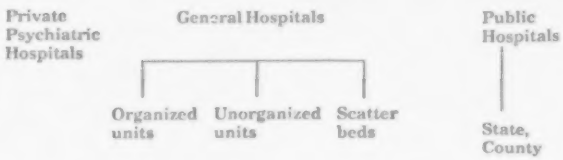
"Seventy-seven percent of the patients in private psychiatric hospitals are discharged to home."

How General and State Hospitals Fit in the System

Psychiatric Units of General Hospitals

While freestanding psychiatric hospitals are uniquely committed to psychiatric services, general hospitals and state facilities also play a role in the inpatient delivery system. This section explains the ways such facilities are organized and most typically used.

Illustration 12: The Inpatient Delivery System



Organized Units

An "organized unit" within a general hospital is defined as an area of a hospital that is set aside for patients with psychiatric diagnoses. Organized units have an identifiable staff structure that provides specific, specialized programs for the mentally ill.

Most organized units are designed to provide short-term inpatient treatment for those patients with diagnoses indicating a moderate severity of illness, and often with a concurrent physical disorder. In addition, the organized psychiatric unit often provides triage and diagnostic services.

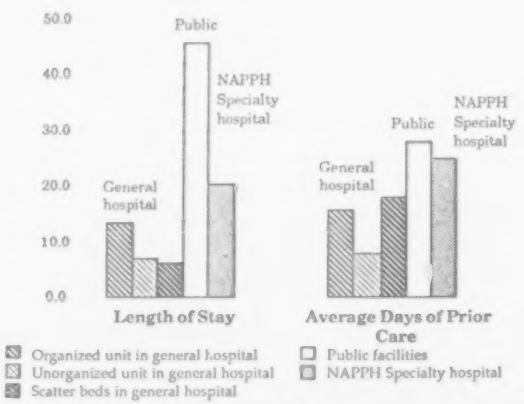
General hospital psychiatric units generally provide a singular level of care and often do not offer the wide array of specialized services needed for more severe cases. Unlike NAPPH specialty hospitals, many general hospital units may not have such services as occupational and rehabilitative therapy, staffed school programs for children and adolescents, and clinical social work support services. Similarly, space may not be available in a general hospital program to provide separate treatment areas for adolescents and adults.

Unorganized Units

An "unorganized unit" also has a separate area designated within a medical/surgical hospital. However, unorganized units have never been surveyed for staffing by licensing personnel or Federal surveyors specifically for psychiatric care. There are not necessarily professional psychiatric staff designated and assigned to this type of unit.

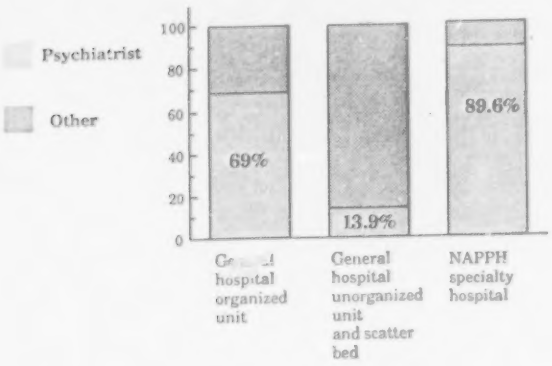
Often the unorganized unit has no accommodations for a protective patient environment, rarely offering locked units or seclusion rooms for the patient requiring such restrictions.

Illustration 13: Length of Stay and Average Days of Prior Care in Various Treatment Facilities



The length of stay in general hospitals indicate the triage, stabilization and referral orientation of these hospitals. Specially psychiatric hospitals usually see a more disturbed patient population that has had many more days of prior psychiatric care than those seen in general hospitals.

Illustration 14: Percent of Psychiatric Staff in Various Hospitalization Settings



Psychiatrists are in charge of medical treatment in private psychiatric hospitals. In contrast, over 86% of the patients with primary psychiatric diagnoses in general hospital scatter beds have no direct treatment by a psychiatrist.

According to the National Institute of Mental Health, general hospital psychiatric units primarily treat patients with affective disorders, acute episodes of schizophrenia, and non-psychotic diagnoses. The average length of stay, at 12 to 13 days, demonstrates the triage and referral orientation of these units. These numbers are further diminished when reviewing the unorganized unit length of stay at 7 days, with primary admission diagnosis being alcohol and substance induced organic mental syndrome. The National Center for Health Services Research and Health Care Technology Assessment (NCHSR) found that the unorganized units discharge significantly more of their psychiatric patients to other settings, primarily the psychiatric specialty hospital, when severely psychotic diagnoses are present.[5]

General Hospital Scatter Beds

"Scatter beds" are general hospital beds used for a variety of medical illnesses, including psychiatric disease, and are located throughout the hospital. In fact, it is the patient's disease that determines the bed designation, so bed use changes literally from day to day. Professional staffing and medical services are delivered most often by general medical specialists, with no psychiatric treatment team or trained mental illness specialist involvement.

Only 13.9 percent of the psychiatric patients admitted into the scatter bed setting are under the professional care of a psychiatrist.

Fifty-two percent of patient care delivered in scatter beds is by a general practitioner or internist.

There is professional concensus that treatment of a mental illness within a scatter bed environment is less than definitive, treating the symptoms rather than the etiology of the psychiatric disorder.[9] Involuntary admissions are almost never accepted in this type of treatment environment. Patients are usually mildly psychiatrically impaired.

Scatter beds have no specialized treatment programming. In fact, an NCHSR study found that none of the patients with a principal psychiatric diagnosis in general hospital scatter beds received any psychotherapy during their hospital stay.[5] Most patients are stabilized through drug therapy and then discharged or transferred to a more intensive inpatient treatment environment. In contrast, less than 10 percent of patients in NAPPH psychiatric hospitals are referred to other medical and psychiatric services, including nursing homes. Length of stay in scatter beds is typically no longer than six days, time for evaluation and stabilization of the patient. Nearly 28 percent of Medicare psychiatric discharges are from scatter beds, which do not have the same level of psychiatric specialization found in NAPPH specialty hospitals.

Illustration 15: Percent Specialties in Various Hospitalization Settings

	General hospital organized unit	General hospital unorganized unit and scatter beds	NAPPH Specialty hospital
Psychiatrist	69	14	90
General practicioner	6	23	3
Internist	16	30	4
Other	9	34	8

Data rounded to nearest percent.

Public Psychiatric Facilities

State and county government treatment facilities typically care for the chronically mentally ill, although some states do present treatment alternatives for acutely ill patients.

The National Association of Private Psychiatric Hospitals defines the treatment goals for chronically and acutely ill patients as follows:

- The goal of treatment for a chronically mentally ill person is to prevent further deterioration.
- The goal of treatment for an acutely ill person is to return the individual to optimum functioning and re-entry into their activities of daily living to the maximum extent possible.

Since the majority of resources of public facilites are focused on treating the chronic psychiatric patient, the goals and treatment focus are quite different than the NAPPH specialty hospital.

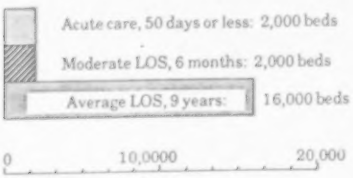
The public psychiatric facility program provides for the activities of daily living in a safe residential setting and in some cases for acute care. In addition, the public psychiatric facility provides for chronic patients with recurring episodes of their illness, who have minimal potential for improvement. These facilites also care for the mentally retarded and the severely brain damaged population.

The average length of stay nationally in the public psychiatric facilities, including general, county and state hospitals, is in excess of 45 days, with 42 percent of discharged patients readmitted within 90 days. In some states, like New York, stays are even longer. The overall readmission rate for public psychiatric facilities exceeds 51 percent. According to the National Institute of Mental Health, involuntary non-criminal admissions are at 51.1 percent in public facilities, with involuntary criminal admissions above 7 percent. In the state of New York, involuntary admissions exceed 60 percent.

Typically public psychiatric facilities provide a mixture of long-term supervisory care (requiring a lesser level of medical attention and generally rendered on a maintenance or custodial level basis) and acute care.

Data released in 1986 by the National Institute of Mental Health shows that the number of public psychiatric facility beds decreased from 279,274 in January 1974 to 128,626 in January, 1984. This represents a 53.9 percent decrease within that time period. These reductions result from decreased federal, state, and county funds in addition to the emphasis toward deinstitutionalization and have contributed largely to the growing "street people" populations. Unfortunately, studies have shown that alternative treatment settings are not available in sufficient quantity or uniformly distributed to care for the chronically mentally ill.[10] Outcrys from organizations such as the National Association of Private Psychiatric Hospitals, the National Alliance for the Mentally Ill, the American Mental Health Fund, the National Mental Health Association, and the American Psychiatric Association clearly call for an adequate provision of the full spectrum of mental health services in order to care for the mentally ill of this country.

Illustration 16: Number of Beds Operated by New York State in Relation to Length of Stay



Many states make a policy commitment to custodial care, as underscored by New York state's designation of 16,000 beds for custodial care. However, most states cannot affford to make this level of commitment. The average length of stay (LOS) in public hospitals nationally is 45 days with 42% of discharged patients readmitted within 90 days.

Thoughts for Benefit Managers: Using Inpatient Benefits Wisely

Inpatient hospitalization is a necessity for psychiatric patients whose illness is both severe and debilitating. Finding the most appropriate setting for any single patient requires an understanding of the diversity of inpatient options.

❑ Recognize that there are differences in inpatient settings for psychiatric treatment.

There are private specialty hospitals that offer a full array of programming for all age groups. There are general hospital units organized to provide psychiatric care. There are also "scatter beds" in general hospitals—where a psychiatric patient may be housed with a patient with another diagnosis and where no active psychiatric program is provided.

Each of these settings is staffed, equipped, and constructed to serve patients with varying levels of severity.

❑ Check the individual patient's severity of psychiatric illness and level of impairment.

Diagnosis is not an indicator of which setting will best serve the patient. For example, two patients with the very same diagnosis almost certainly will have different histories, support systems, and varying degrees of manifestation of the symptoms of their illness in their behavior. One properly diagnosed schizophrenic patient may have an encapsulated psychosis that does not cause the patient to act on the psychotic thinking caused by the disease. Another schizophrenic patient may act out hallucinations and, therefore, be more severely ill.

Similarly patients with depression may all have problems with eating, sleeping, sexuality, or work performance. However, one patient may be able to work through a crisis because of excellent support systems. Another may have similar symptoms, but may be so impaired that weight loss is out of control, or thoughts of suicide become increasingly concrete. In all cases, it is the degree to which symptoms are debilitating that sways decisions about the appropriate setting for treatment.

❑ Match the patient with the appropriate setting.

For example, an adolescent may best be served by a specialty hospital that can provide treatment with peers by clinicians trained in adolescent issues, that can include the family in treatment, and that can integrate school as a part of treatment.

❑ Recognize that treatment needs may change over time.

For just that reason, NAPPH psychiatric hospitals have developed a continuum of care from outpatient to partial hospitalization to specialized longer-term services. The availability of a full continuum allows patients to receive the appropriate level of care to match the severity of their illness with as little disruption to their lives as possible.

NAPPH Philosophy

The primary mission of NAPPH psychiatric specialty hospitals is to provide quality treatment for the moderately to severely psychiatrically mentally ill by offering a comprehensive range of services to treat all levels of impairment. The length of stay and cost of service are reflections of the patient's severity of illness and resulting level of impairment.

Each sector of inpatient psychiatric care provides a level of treatment that combines physical resources, overall hospital mission, and a service commitment to the disease of mental illness.

The costs to society for not providing early and appropriate psychiatric care will inevitably lead to a much higher cost to society through the subsidization of the justice system, the welfare system, and the penal system. The "street populations" and overflowing penal system are testaments to the public policy decision to mainstream deinstitutionalized individuals without adequate community support or aftercare services. The availability and use of drugs by adults, adolescents, and children as well as the alarming teenage suicide rate are reflective of the complexities of today's changing society.

All of these issues directly affect individuals, communities, corporations, and public policy makers both in terms of cost and responsibilities. Since studies have clearly indicated the

economic benefits of treating troubled employees, it makes good financial sense to provide comprehensive mental health benefits.[13] It is society's responsibility to see that those who need psychiatric care receive it at the level required and to ensure that those individuals are integrated back into a society that allows them to achieve maximum productivity.

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Sources for Data Used in Illustrations

Illustration 2: Alcohol, Drug Abuse, and Mental Health Administration.

Illustration 3: *Mental Health, United States*, 1985, NIMH.

Illustration 4: Health Care Financing Administration; limited to Medicare approved units.

Illustration 5: 1986 NAPPH Annual Survey.

Illustration 6: Medpar, 1982–1983 (Medicare only).

Illustration 7: 1986 NAPPH Survey.

Illustration 8: *Hospital Statistics, 1983*, American Hospital Association.

Illustration 9: 1986 NAPPH Annual Survey.

Illustration 10: 1986 NAPPH Annual Survey.

Illustration 11: NIMH, published by Drexel, Burnham, Lambert, May 1986.

Illustration 13: Merged data American Hospital Association, National Institute of Mental Health, National Association of Private Psychiatric Hospitals, and National Association of State Mental Health Directors.

Illustration 14 and 15: Merged data American Hospital Association, National Institute of Mental Health, National Association of Private Psychiatric Hospitals, and National Association of State Mental Health Directors.

Illustration 16: Inteview with Mental Health Commissioner, state of New York, October 1986.

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Richard Moss Publishing+Design

STATEMENT OF ALAN SPIELMAN, EXECUTIVE DIRECTOR, GOVERNMENT PROGRAMS LEGISLATION, BLUE CROSS AND BLUE SHIELD ASSOCIATION, WASHINGTON, DC

Mr. SPIELMAN. Thank you, Mr. Chairman. Once again, we are pleased to be here to testify on a subject of expanding Medicare benefits, and again we hope that our experience as Medicare intermediaries and carriers, and our private market experience will be of help to you.

In the private market, virtually all of our 70 million nonelderly subscribers and their dependents have some form of mental health coverage. The extent of this coverage varies in part to reflect the different preferences of our accounts.

My written statement provides details on what these coverages are.

Because of the potentially large cost involved, effective benefit design and management is critical to containing mental health coverage cost. Appropriate patient cost sharing, mechanisms to manage the utilization of services, and in some cases, patient incentives to use the most cost effective providers are all important to the management of mental health benefits.

Utilization of mental health benefits has been of particular concern to third-party payers. As a result, specific limits on the dollar value of benefits payable or on the number of visits that will be covered, as well as patient coinsurance higher than that applied to other services are often used to help contain benefit costs to reasonable levels.

The Medicare supplemental coverage offered by Blue Cross and Blue Shield Plans generally does not provide mental health benefits beyond those covered by Medicare, although coverage of the inpatient hospital deductible is common.

You heard from other witnesses the details concerning Medicare's current benefits, and, of course, the proposals that are on the table are quite familiar to you so I will not go into detail on those.

In this area, we believe that if the Congress decides additional Medicare spending is appropriate, it is reasonable to consider some expansion of the mental health benefit. Currently, relatively few beneficiaries use these services, but existing limits can create access problems and financial burdens in individual cases. Expanding inpatient and outpatient mental health benefits in the context of catastrophic coverage would, therefore, be appropriate.

As you consider proposals in this area, we would like to suggest four principles of design and administration. The first is simplicity; the second is balancing beneficiary cost sharing with financial access; the third is adequate utilization management; and the fourth is the equitable financing of the benefit.

The simpler the benefit, the easier it is for beneficiaries and providers to understand and for Medicare intermediaries and carriers to implement. Either increasing the current dollar cap on outpatient coverage or setting a cap on the number of visits would be simplest. In this area we believe a cap on visits is the best approach.

Regarding beneficiary cost sharing, a reasonable level is desirable to deter unnecessary care while providing sufficient financial

access. It would be reasonable, albeit costly, to lower the coinsurance from the current 50 percent. We would, however, recommend against eliminating entirely any distinction between the coinsurance on mental health benefits and that applicable to other Part B services.

While the coinsurance level is one way to encourage appropriate utilization, another approach is through the review of the medical necessity and appropriateness of mental health services. Medicare contractor activities in this area should be continued and encouraged.

Finally, in regard to financing, a key issue is whether current beneficiaries will be required to finance fully the benefit expansion or whether it will simply be incorporated in the current financing mechanisms for Part A or Part B. If the benefit is to be fully financed by current beneficiaries, and the cost of the benefit expansion is substantial, we believe it should be accomplished through an income-related approach, such as the beneficiary premium surcharge included in the pending catastrophic coverage bill.

In summary, expanding Medicare's outpatient mental health benefit is an appropriate option for Congress to consider if adequate financing sources are available and appropriate design and administrative features are included. We believe that increasing the cap and stating it in terms of visits, while maintaining the current coinsurance, probably would be the best approach. Such an expansion is the simplest to understand and administer; it permits the use of carriers' existing utilization review mechanisms; and emphasizes protection for higher cost patients.

We also support consideration of replacing the inpatient psychiatric lifetime day limit with an appropriate annual limit in order to provide better protection from catastrophic expenses.

In conclusion, we would be pleased to provide any further information on our Medicare experience or experience in the private health insurance market in this area. Thank you.

[The prepared written statement of Mr. Spielman follows:]

TESTIMONY

of the

BLUE CROSS AND BLUE SHIELD ASSOCIATION

on

EXPANSION OF MENTAL HEALTH BENEFITS UNDER MEDICARE

before the

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

UNITED STATES SENATE

by

Alan P. Spielman
Executive Director
Government Programs Legislation

Thursday, June 18, 1987

Mr. Chairman and Members of the subcommittee, I am Alan P. Spielman, Executive Director of Government Programs Legislation for the Blue Cross and Blue Shield Association. We appreciate this opportunity to testify on expanding mental health benefits under Medicare. As fiscal intermediaries and carriers, the Association and Blue Cross and Blue Shield Plans have administered Medicare mental health benefits since the beginning of the program. In addition, the Blue Cross and Blue Shield organization has experience in the design and management of mental health benefits in the private health insurance market.

We believe a summary of our experience with mental health benefits under both Medicare and private insurance may be helpful to the subcommittee. We would like to provide details on Plans' mental health coverage and suggest principles of benefit design and administration for Medicare.

In the private market, virtually all of our 70 million non-elderly subscribers and their dependents have mental health coverage. The extent of this coverage varies in part to reflect the different preferences of our accounts. For inpatient mental health care, Plans generally provide coverage for a specified number of days with only limited cost sharing. On outpatient mental health care, about 80% of Plans generally require patient coinsurance of 50 percent, subject to account preferences and state laws, with the balance of Plans requiring 20% coinsurance. Mental health benefits either are included in the basic coverage package, in major medical coverage, or in a separate program, depending on state requirements and account requests.

Benefits under the Blue Cross and Blue Shield Federal Employee Program (FEP) include inpatient hospital care for treatment of mental illness and outpatient mental health

care up to an annual maximum. FEP high option covers up to 50 outpatient visits per year with 30% coinsurance and a $200 overall deductible on medical services. High option catastrophic psychiatric coverage pays for all medically necessary inpatient mental health services once out-of-pocket liability exceeds $4,000, up to a $75,000 lifetime payment. Standard option covers up to 25 outpatient visits with 25% coinsurance and a $250 overall medical deductible. Standard option catastrophic coverage pays for all necessary inpatient mental health services after out-of-pocket expenses of $8,000, subject to a $50,000 lifetime reimbursement.

The Medicare supplemental coverage offered by Blue Cross and Blue Shield Plans generally does not provide mental health benefits beyond those covered by Medicare. However, most Blue Cross and Blue Shield Plan Medigap products cover Medicare hospital deductibles, including those incurred for psychiatric hospitalizations.

Most Plans monitor high-cost cases and unusual provider practice patterns. Several Plans are using innovative arrangements such as preferred provider arrangements and "participation" status for providers meeting specified qualifications, such as maintaining an auditable utilization review program.

Current Medicare Mental Health Coverage and Cost

Under Part A, Medicare covers inpatient psychiatric services to the same extent as other inpatient hospital services, except that psychiatric care is subject to a 190-day lifetime limit. About 100,000 beneficiaries used inpatient psychiatric services in 1985 at a cost of $550 million, according to the Congressional Budget Office (CBO). Data from HCFA show that about 10,000 beneficiaries have exhausted their 190-day Part A psychiatric hospital limit, a number that increases by about 1,000 annually.

Under Part B, Medicare pays 50% of allowed charges for outpatient mental health care, up to an annual payment limit of $250. Charges for initial psychiatric diagnostic services are not subject to this limit. Roughly 465,000 beneficiaries received covered outpatient mental health care in 1985 at a cost of $47 million, according to CBO. In 1985 about 46,000 beneficiaries under Part B exhausted their mental health coverage.

While relatively few beneficiaries exhaust Medicare mental health coverage, those who do may face catastrophic expenses. For other beneficiaries, combined out-of-pocket spending for mental health care and other services could be a financial burden. In the context of Medicare catastrophic coverage, we believe it is appropriate to consider what mental health benefit changes may be desirable.

Proposals to Expand Mental Health Coverage

Three bills to expand mental health coverage are receiving considerable congressional attention. S. 1209, introduced by Senator Durenberger, would increase the Part B cap on outpatient mental health services from $250 to $1,215 for certain "high use" services and eliminate the cap for other mental health services. The beneficiary coinsurance percentage would vary from 20% to 50% depending on the type of service and the visit number. In addition, the bill would impose an annual limit of 30 visits for high use services.

The Medicare Mental Illness Non-Discrimation Act, S. 718, introduced by Senator Matsunaga and as H.R. 1067 by Representative Downey, would remove the current limits on both inpatient psychiatric days and outpatient reimbursement.

H.R. 2470, the Medicare catastrophic coverage bill as reported by the House Ways and Means Committee, would increase the Part B mental health payment cap to $1,000 per

year. The House Energy and Commerce Health Subcommittee version of H.R. 2470 would replace the dollar cap with a 25-visit limit and exclude "medical management" services from the limit. Both versions of H.R. 2470 would count a maximum of $250 in beneficiary outpatient coinsurance toward the Part B catastrophic stop loss.

Blue Cross and Blue Shield Position

If Congress decides additional Medicare spending is appropriate, it is reasonable to consider some expansion of mental health benefits. Currently, relatively few beneficiaries use these services, but existing limits can create access problems and financial burdens in individual cases. Thus, it may be appropriate to consider expanding inpatient and outpatient mental health benefits in the context of catastrophic coverage.

While Medicare spending for mental health benefits is relatively low today, it is important to consider the potential for rapid cost increases when reviewing proposals to expand Medicare benefits in this area. CBO estimates that eliminating the inpatient psychiatric lifetime limit would cost $2.2 billion over the next five years, while eliminating the Part B cap (but retaining 50% coinsurance) could cost $1.7 billion over the same period.

Because of the potentially large costs involved, effective benefit design and management is critical to containing the costs of mental health coverage. Appropriate patient cost sharing, mechanisms to manage the utilization of services including limitations on the scope of benefits provided, and in some cases, patient incentives to use the most cost-effective providers are all important to the management of mental health benefits. The utilization of mental health benefits is of particular concern to third party payers. The state-of-the-art for utilization review of mental health

benefits generally lags behind that for treatment of physical illness and injury. Moreover, patients themselves may exercise a much greater influence over the frequency of outpatient mental health treatments than for other services. As a result, specific limits on the dollar value of benefits payable or on the number of visits that will be covered, as well as patient coinsurance higher than that applied to other services, are often used to help contain benefit costs to reasonable levels.

Benefit Design and Administration

As the subcommittee considers proposals to expand mental health benefits under Medicare, we would suggest four principles for benefit design and administration. These are:

1) Simplicity of design,
2) An appropriate balance between beneficiary cost sharing and financial protection,
3) Adequate utilization control, and
4) Equitable financing.

Simplicity

The simpler the benefit, the easier for beneficiaries and providers to understand and for Medicare intermediaries and carriers to administer. Either increasing the current dollar cap on outpatient coverage, as in the Ways and Means version of H.R. 2470, or setting a cap on the number of visits, as in the Energy and Commerce Health Subcommittee version of that bill, would be simplest. Conversely, proposals to impose differential cost sharing percentages depending on the type of service or the number of visits could be confusing and difficult to administer. However, we do not believe an administrative problem would be created by exempting "medical management" services, such as periodic prescription drug monitoring, from the limit.

Beneficiary Cost Sharing

In regard to beneficiary expenses, a reasonable level of cost sharing is desirable to deter unnecessary care while providing sufficient financial access. Similarly, the level of a cap on Medicare reimbursement ideally should not create an incentive to over-utilize care.

We would note that very few Medigap policies pay for outpatient mental health care once the Medicare payment cap is exceeded, so an adequate cap is perhaps the most important design feature. One issue relating to a benefit cap is whether it should be based on a dollar amount (e.g. the Ways and Means version of H.R. 2470), the number of visits (e.g. the Energy and Commerce Health Subcommittee version of H.R. 2470), or a combination (S. 1209). Simply raising the dollar cap today would not keep pace with future inflation, thus eroding the benefit's value. A solution would be to index the dollar limit. Using a visit limit also avoids the value erosion problem and has the advantage of providing all beneficiaries, regardless of whether they live in a high or low cost area, with the same scope of benefits. However, if the visit limit is high, costs could increase rapidly. We would point out that the dollar value of the number of visits allowed under the Energy and Commerce version of H.R. 2470 would appear to be more generous than if the $250 cap set in 1965 simply were adjusted for subsequent inflation. A combination of dollar and visit limits could be designed as a middle ground but at the expense of simplicity. On balance, we believe a cap on visits only is most appropriate.

Regarding the beneficiary's out-of-pocket expense, it would be reasonable, albeit costly, to lower the coinsurance from the current 50 percent. We would, however, recommend against eliminating entirely any distinction between the coinsurance on mental health benefits and that for other Part B services.

We also suggest that Congress consider altering Medicare's 190-day lifetime limit on inpatient mental health care. This would protect those relatively few beneficiaries who could incur catastrophic expenses for severe psychiatric illnesses. We recognize that such a change could be costly but believe expenses could be restrained through stringent utilization review. One approach being discussed would replace the current lifetime limit with an annual limit. This would help assure that expenses would not escalate from episodes of long-term hospitalization while helping protect beneficiaries who need multiple but relatively short hospitalizations over their lifetimes. Such an approach would pose no administrative problems.

Utilization Review

While the coinsurance level is one way to encourage appropriate utilization, another approach is the review of the medical necessity and appropriateness of mental health care. These reviews, which are conducted by Medicare carriers and intermediaries, include reviewing cases when the number of visits exceeds the norm for particular diagnoses. Blue Cross and Blue Shield Plans also conduct utilization review for their privately insured subscribers. Some Plans perform case management for subscribers using extensive mental health care. Plans generally also perform claims reviews to identify and investigate unusual service patterns of particular providers. This latter process is similar to postpayment reviews done by Medicare contractors.

Financing

Finally, in regard to financing, a key issue is whether current beneficiaries will be required to finance fully the benefit expansion or whether it will simply be incorporated into the current financing mechanisms for Part A or Part B of the program. If the benefit is to be fully financed by beneficiaries and the cost of the benefit is significant, we believe that it should be accomplished through an income-related approach such as

the beneficiary premium surcharge included in the pending catastrophic coverage bills. The alternative, simply increasing the Part B premium to finance the new benefits, could be financially burdensome to some beneficiaries in view of the expected premium increase under current law and the pending premium increases for other benefits.

Summary

In summary, expanding Medicare's outpatient mental health benefit is an appropriate option for Congress to consider if adequate financing sources are available and appropriate design and administrative features are included.

We believe a benefit expansion along the lines of that proposed in the Energy and Commerce Health Subcommittee version of H.R. 2470 — that is, increasing the cap and stating it in terms of visits, while maintaining 50% coinsurance — probably would be best approach. Such an expansion is the simplest to understand and administer, permits use of carriers' existing utilization control mechanisms, and emphasizes protection for higher-cost patients while retaining reasonable coinsurance levels. We also support consideration of replacing the inpatient psychiatric lifetime day limit with an appropriate annual limit in order to provide better protection from catastrophic expenses. Finally, if the expanded benefits are to be fully financed by beneficiaries, we recommend consideration of income-related financing options.

We would be pleased to provide any further information on our Medicare and private business experience with administering mental health benefits and look forward to working with you on this important issue.

934:6/16/87

Senator MITCHELL. Thank you, Mr. Spielman.

Senator Durenberger, do you have any questions?

Senator DURENBERGER. No. I just want to express my personal appreciation to each of the witnesses and the associations for the thoroughness of their statements, and for the support that over the years they have given to mental health, which just now hopefully is about to bear fruit. So I am simply grateful to you and I am grateful just to be here to have the opportunity to be able to facilitate this very realistic clarification of benefit. Thank you very much.

Senator MITCHELL. Well I share Senator Durenberger's gratitude and we look forward to working with all of you on this important issue in the near future. Thank you very much. The hearing is concluded.

[Whereupon, at 12:50 p.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

STATEMENT OF

THE NATIONAL FEDERATION OF SOCIETIES

FOR CLINICAL SOCIAL WORK, INC.

ON MEDICARE COVERAGE FOR

OUTPATIENT MENTAL HEALTH CARE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

JUNE 18, 1987

2101 L Street, N.W.
Washington, D.C. 20037
(202) 785-9700

NATIONAL FEDERATION OF
SOCIETIES FOR CLINICAL SOCIAL WORK, INC.

The National Federation of Societies for Clinical Social Work is pleased to have this opportunity to present the views of the clinical social work profession on issues relating to mental health coverage under the Medicare program. The National Federation represents thousands of clinical social workers around the country who are engaged in providing mental health services to individuals, families and groups, in private practice, in group practice settings, in HMOs, PPOs, EPOs, IPAs, in public and private clinics and agencies, and in hospitals.

THE NEED FOR IMPROVED OUTPATIENT MENTAL HEALTH COVERAGE UNDER MEDICARE

Medicare's outpatient mental health benefit may have been adequate when it was established over 20 years ago, when we knew very little about mental illness, but our understanding and treatment of mental health disorders have improved dramatically since then. Yet the amount that Medicare will pay for outpatient treatment of mental health problems has remained the same, even in the face of 20 years of inflation.

By limiting coverage to $250 a year for outpatient mental health treatment, Medicare clearly discriminates against mental illness by treating it as less significant than physical ailments. This difference in coverage of physical and mental illness should not be tolerated any longer. Our progressive understanding of health in recent years has increased our awareness that physical

and mental health are inextricably connected. Studies have consistently shown that many patients going to physicians' offices for physical complaints have emotional and psychological problems which either have caused or aggravated the physical condition.

We urge Congress to end the discriminatory treatment of mental illness under Medicare and enact a meaningful increase in the outpatient mental health benefit. This year, the House Ways and Means and Energy and Commerce Committees have voted to increase the outpatient mental health benefit by raising the current annual outpatient limit from $250 to $1,000. We applaud the efforts of both committees to improve mental health coverage under Medicare; however, we suggest that the dollar limit be changed to a visit limit in order to avoid the need to amend the law as the purchasing power of the dollar limit fluctuates over the years. Furthermore, in order to maximize the cost-effectiveness of the covered service, we urge that beneficiaries be given freedom of choice, so they can obtain covered services from any qualified mental health professional without regard to professional discipline. Specifically, we endorse the following approach to outpatient benefits, proposed recently by the Mental Health Law Project with the support of numerous mental health organizations:

> "Twenty-five visits to an eligible mental health professional for individual, group or family, or other form of psychotherapy should be covered. The eligible professional should be determined by state licensure and professional practice laws. Both public and private individual and group practice arrangements would be eligible to provide services.

MEDICARE'S RESTRICTIVE REIMBURSEMENT POLICY

Although an increase in the outpatient mental health benefit would do much to help some elderly beneficiaries pay for needed mental health services, as well as begin to bridge the gap in coverage between physical and mental health care, it would do little to make mental health services available to a large segment of the Medicare population unless it is coupled with freedom of choice among qualified providers. The mental health delivery system in the United States has grown up over the years around the availability of a number of qualified mental health professionals, without regard to the discipline of the provider, yet Medicare currently will only pay for services rendered by a physician. The law does not even require that the services be performed by a trained mental health professional -- any physician will do. In this respect, the 20-year old Medicare program is out of step with the realities of today's mental health delivery system, which is universally recognized to consist of four "core disciplines" -- psychiatry, psychology, clinical social work, and psychiatric nursing. Consequently, many of the nation's elderly are often denied the freedom to select from a range of qualified providers simply because the therapist of their choice may be a clinical social worker and is excluded from the Medicare financing structure.

UNMET MENTAL HEALTH NEEDS OF THE ELDERLY

Several years ago, the President's Commission on Mental Health conducted an analysis of governmental policy in the area of mental health service delivery, with particular focus on underserved populations. Many older Americans were found to have insufficient access to services or to personnel trained to respond to the special needs of the elderly.1/ Moreover, the Commission found that the elderly have a greater need for mental health services than the general population (up to 25% of older persons are estimated to have significant mental health problems).2/

Since then, other studies and reports have confirmed the findings of the President's Commission. A recent General Accounting Office report determined once again that the elderly do not have adequate access to mental health services.3/ And a 1984 study by the Department of Health and Human Services found that less than 4 percent of psychiatrists' visits are provided to persons over age 65, even though this age group accounts for almost 20 percent of office visits generally.4/ Further, the study documents the fact that four out of five persons age 65 or older with a mental illness are seen by non-psychiatrist physicians.5/

THE NEED FOR FREEDOM OF CHOICE

Insufficient access to mental health services and to trained mental health professionals led the President's Commission to recommend that Medicare and other publicly financed mental health service programs should provide direct reimbursement to all

independent qualified mental health professionals including the four core disciplines, who meet the requisite standards of education, experience and professional licensure/certification.6/ The fundamental point made by the Commission was that federal financing mechanisms should be based upon the appropriateness of care, not the discipline of the provider.7/

It is particularly ironic that Congress, on the one hand, has appropriated funds over the years to train clinical social workers, under such programs as the National Mental Health Act of 1946, and, on the other hand, has excluded them from participation in the Medicare delivery system:

> ". . . [A] major barrier to outpatient care for populations with special needs is imposed by the public mechanisms for financing their mental health care -- Medicare and Medicaid . . . . Federal financing mechanisms have often worked at cross-purposes to federally initiated service delivery programs."8/

It is also ironic that at the same time Congress has guaranteed the patient through the Medicare law "freedom of choice" in selecting a provider, it has restricted that choice to only one class of provider -- physicians.

The President's Commission on Mental Health has not been alone in urging that the mental health delivery structure allow the consumer "freedom of choice" in selecting among qualified providers. Several years ago, Lewin and Associates, Inc. published the results of a study prepared for the Federal Trade Commission on competition among health practitioners, which examined the influence of the medical profession on the health manpower market.

The study concluded that one of the principal ways to broaden consumer choice, and to diminish the monopoly power of physicians, was to allow consumers the freedom to select among a variety of health professionals. "If carefully designed, a system based on broadened choice could preserve professional competency while increasing competition among providers on the basis of the service they provide, quality, and price."9/ The study warned that "unreasonable resistance to change in present manpower arrangements has, in some cases, prevented appropriate utilization of health resources and possibly raised the cost of care."10/

There is no basis for concern that expanding the provider pool to include qualified non-physician mental health professionals will adversely affect therapeutic outcome. To the contrary, research has demonstrated there is no measurable difference in outcome on the basis of provider discipline.11/

"Freedom of choice" can be a critical element in the patient's acknowledgment that he or she needs treatment, in the patient's actual resort to treatment, and in the relationship of trust and confidence in the psychotherapist necessary to make that treatment successful. Medicare beneficiaries should not be denied the opportunity to select from a range of qualified providers merely because the therapist of their choice is a clinical social worker, and not a physician.

THE FEHBP AND CHAMPUS EXPERIENCE

Other federally funded health insurance programs have recognized the importance of utilizing the services of clinical

social workers and other qualified non-physician mental health professionals. A 1986 study conducted by the Office of Personnel Management examined the effects of providing direct reimbursement to clinical social workers and other non-physician providers under the Federal Employees Health Benefits Program (FEHBP). The results of the study were encouraging. OPM concluded there was no basis to anticipate adverse impact on cost or quality of care from mandating coverage of non-physician providers, including clinical social workers.12/

The CHAMPUS program reports a similar experience. In 1980 Congress directed CHAMPUS to conduct a demonstration project by including clinical social workers as independent providers of covered services for a period of two years, in order to assess the impact on cost and utilization. In 1982, following the experimental period, Congress authorized continuation of the independent provider status, based on the finding from the demonstration project that "no quality of care problems have arisen, and reimbursement of clinical social workers costs less than the traditional physician gate-keeper approach.13/

COST OFFSETS OF MENTAL HEALTH TREATMENT

In past years, some opponents of freedom of choice have argued that expanding the available provider base will cause a large increase in utilization, at additional cost to the government. Even if utilization were to increase with the inclusion of clinical social workers in the Medicare provider base, overall program costs would not necessarily increase proportionately. To

the contrary, the evidence strongly suggests that increased utilization would be offset by corresponding cost savings.

For example, the President's Commission on Mental Health concluded that increased utilization of mental health services yields decreased utilization of (more expensive) doctors, hospitals and surgery. "[A]s a group, this research is most striking", the Commission reported. "Research from health maintenance organizations (HMO's), from industrial programs, and from regular health insurance plans suggests that providing outpatient mental health services can reduce overall health services utilization and overall health costs.14/

The Commission also determined that as many as 60 percent or more of physician visits are from sufferers of emotional distress rather than diagnosable illness.15/ A similar finding was reported by the Department of Health and Human Services, in its study report titled "The Hidden Mental Health Network."16/

An article published by Jones and Vischi of the Alcohol, Drug Abuse and Mental Health Administration, summarized the results of twelve separate studies which have demonstrated that the cost of providing mental health services was offset by a significant decline in medical utilization.17/

One of the most recent studies relating to the offset effect of mental health treatment on medical costs is a 1983 study on outpatient mental health treatment following the onset of a chronic disease. The findings indicate that outpatient psycho-

therapy beginning within one year of the diagnosis of one of four chronic diseases is associated with reduced charges for medical services by the third year following the diagnosis.18/ The authors conclude that the study "adds weight to the conclusion drawn from the reviews of the scientific literature that the inclusion of outpatient psychotherapy in medical care systems can improve the quality and appropriateness of care and also lower costs of providing it."19/

CONCLUSION

It is clear that the cost of leaving the mental health needs of our elderly unattended are enormous both in human and social terms. From the standpoint of just the dollars and cents involved, it has to cost more to keep paying the physician, laboratory, x-ray, surgical and hospital bills to treat the symptoms of underlying mental and emotional problems which can be more effectively (and inexpensively) dealt with by a trained mental health professional -- physician or non-physician.

It is time that benefit levels be updated to account for decades of inflation, and that the Medicare delivery system recognize as independent providers clinical social workers and other qualified non-physician mental health professionals who are currently providing the majority of the mental health services throughout the country.

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